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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 2/21/17 through 2/22/17. An extended survey was conducted 2/22/17 through 2/23/17. One complaint was investigated. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Immediate Jeopardy was identified in the area of Freedom from Abuse, Neglect, Exploitation at a Scope and Severity Level 4, widespread, and which constituted Substandard Quality of Care. After accepting the Administrator's plan for removal of the Immediate Jeopardy and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level 2, pattern. The census in this 120 certified bed facility was 105 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Resident #1 through #10) .	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 157		3/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/14/2017

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physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:

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F 157	Continued From page 2 Based on staff interviews, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to immediately consult with the Physician and notify the Resident Representative for the need to alter treatment significantly for the implementation of a physical restraint to prevent movement for 2 of 10 residents in the survey sample, Resident #1 and #3, 1. The facility staff failed to immediately consult with Resident #1's Physician and notify the Resident Representative for the need to alter treatment prior to the implementation of a gait belt as a physical restraint to prevent movement on 2/9/17. A gait belt was utilized to prevent the resident from rising from the wheelchair from approximately 8:00 pm on 2/9/17 until 10:00-10:30 am the following morning on 2/10/17. 2. The facility staff failed to immediately consult with Resident #3's Physician and notify the Resident Representative for the need to alter treatment prior to the implementation of a gait belt as a physical restraint to prevent movement on 1/9/17. The findings included: 1. The State Survey Agency received an anonymous complaint on February 15, 2017. The complaint alleged a resident had been left in a chair restrained all day and overnight. The resident identified in the complaint was Resident #1. Resident #1 was originally admitted to the facility on 12/23/16 and readmitted on 1/4/17 following a short hospital stay from 12/28/16 through 1/4/17	F 157	F 157 1. A MD and RP notified on 2/22/17 re: past use of the restraint for res. # 1 & 3. B. No gait belt (used as a restraint) or any other restraint is in use at this time. 2. All residents are at risk for this issue. 3. A. In-service for licensed nursing staff by the ADON on the regulation and facility policy on the use of restraints to include: - notification of MD & RP - identification of the medical need for a restraint - obtaining an order and parameters for use 3.B The ADON or designee will in-service licensed nursing staff that no restraint order will be initiated with the MD before first discussing it with the DON and/or Administrator. 4. Any resident with a restraint will be audited by the DON to ensure the regulation for use and facility policy is followed. This audit will be ongoing and all audit results will be shared in QAPI meetings. 5. 3/17/17	

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for acute urinary retention (1). Diagnoses included BPH (benign prostatic hyperplasia), and Alzheimer's dementia.

The current MDS (Minimum Data Set) a 30 day with an assessment reference date (ARD) of 1/31/17 coded the resident as scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status), indicating the resident had severely impaired daily decision making skills. The resident was coded as having inattention and disorganized thinking. The resident did not exhibit any behaviors. The resident was able to walk between locations in his/her room and in the corridor on the unit with limited assistance of one staff. Mobility devices used were a walker and wheelchair. The resident had a Foley catheter for bladder drainage. Under Section J. 1800 Fall history coded the resident as not having any falls since Admission/Entry or Reentry or Prior Assessment. This was inaccurate as the clinical record and the comprehensive Resident Centered Plan of Care evidenced the resident had a fall on 1/8/17 which is prior to the ARD.

The Resident Centered Plan of Care initiated 12/24/16 evidenced the resident was identified as at risk for falls/impaired safety related to confusion related to Alzheimer's dementia, poor vision related to glaucoma, history of chronic leg ulcers and debility. Fall on 1/8/17 and fall on 2/9/17. The goal was the resident will not sustain an injury due to a fall through review. Interventions listed to prevent falls and promote safety did not include the use of a physical restraint.

On 2/21/17 at 3:20 am, the Director of Nursing (DON) was interviewed about the allegation of

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Resident #1 being restrained with a gait belt. While in the DON's office this surveyor was provided with a copy of a facility's investigation report of this allegation dated 2/10/17. This report noted Resident #1 "was found with a gait belt restraining him to the chair". The DON was asked if the Physician and the Resident Representative were notified by the facility that a gait belt was used to restrain Resident #1, she stated, "No".

The Physician Order Summary Report for Active, Completed, Discontinued date range 1/1/17 through 2/28/17 was reviewed. There were no physician order(s) obtained that specified type of restraint, reason for use, and the duration of the restraint per the facility restraint policy dated 7/2015.

The Physician was contacted via phone on 2/21/17 at 11:00 am. The Physician was asked if the facility had called to obtain an order to restrain the resident, his response was, "No, no one has called me in forever about restraints...whoever does restraints anymore?..."When asked if he was notified that Resident #1 was physically restrained with a gait belt in a wheelchair after notification of a fall on 2/9/17, he stated, "They did not notify me...him being restrained is news to me". When asked, "Would you have expected them (facility) to inform you after they had been made aware the resident was restrained, he responded, "Yes".

The Nursing Progress Notes evidenced the Resident Representative (RR) was not notified immediately of the need to alter treatment significantly with implementation of a physical restraint.

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The clinical record evidenced the Residents Representative was not educated on the risk and benefits of (restraint) device; or a signed Informed Consent for Use of Restraints. Per the facility restraint policy dated 7/2015.

Further investigation evidenced Resident #1 was restrained with a gait belt following a fall on the evening of 2/9/17 at approximately 8:00 pm. to prevent movement. The resident remained at the nurses station for supervision restrained with the gait belt all night. At approximately 10:00-10:30 am on 2/10/17 the Rehab Manager went into the resident's room and observed the resident was asleep, upon attempting to awaken the resident to put him into the bed she observed the gait belt was wrapped around the resident and buckled behind the wheelchair. The Rehab Manager immediately wheeled the resident to the Director of Nursing (DON) office and showed her the restraint. The restraint was immediately removed and the resident was assessed for injury, none was found. A facility investigation was initiated. During the investigation the night shift Licensed Practical Nurse (LPN#1) was suspended for three days (2/10-2/12/17).

After speaking with the Administrator and the Director of Nursing On 2/21/17 of the facility staff failure to immediately consult with and notify the physician for the use of the restraint and failure to notify and inform the RR the survey team was provided a copy of a Nursing Progress note dated 2/21/17 at 2:06 pm. This note was informing the RR of the restraint use, 13 days after the fact and read, in part:"...Spoke with (name of the Resident Representative) and explained an employee had used a gait belt to keep a resident from getting out of his w/c (wheelchair) to prevent him from

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rising up and falling..." The author of this note was the DON.

In addition, the survey team was provided a copy of a Nursing Progress note dated 2/22/17 at 10:53 am, this note was informing the Physician of the restraint use, 13 days after the fact and read: "Late entry from 2/22/17 Call placed to (name of Physician) concerning resident incident with the gait belt. Message left." The author of this note was the DON.

On 2/23/17 at 10:40 am, the Resident Representative (RR) was contacted via phone. The RR stated she was informed yesterday of the gait belt restraint but with "very little details".

The above findings of the facility staff failing to consult the Physician and notify the Resident Representative immediately for the need to alter treatment significantly with the use of a physical restraint was shared during a pre-exit meeting with the Administrator, the DON and the Regional Vice-President of Operations on 2/23/17.

The facility policy titled "Restraints" last revised 7/2015 is documented in part, as follows:
"Policy: Physical and/or chemical restraints will be initiated only after a comprehensive review determines that they are necessary to treat the resident's medical symptoms that warrant their use.

Definitions: Physical Restraint-any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

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Procedure: Physical Restraints

A) Using the Restraint Decision Tree (Form 3.40) determine if the device restricts the residents freedom of movement.
2. If the device restricts freedom of movement it is a restraint.
C) Physician order must be obtained that specifies type of restraint, reason for use, and the duration of the restraint.
D) Resident's responsible party will be educated on risk and benefits of device and sign the Informed Consent for Use of Restraints (Form 3.41)."

Definition:
(1) Urinary retention: The state in which an individual experiences incomplete emptying of the bladder. It is a common complication of benign prostatic hyperplasia (BPH-enlargement of the prostate).
Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

2. The facility staff failed to immediately consult with Resident #3's Physician and notify the Resident Representative for the need to alter treatment prior to the implementation of a gait belt as a physical restraint to prevent movement on 1/9/17.

Resident #3 was a 84 year old admitted to the facility on 11/23/14 with diagnoses to include Psychosis (1), Dementia (2), Major Depressive Disorder (3).

The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 1/16/17. The Brief

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Interview for Mental Status (BIMS) was a 3 out of a possible 15 which indicated Resident #3 was severely cognitively impaired and incapable of daily decision making. Under Section C 1310 Delirium: (A.) Acute Onset Mental Status Changes: the resident was coded 0 indicating no, (B.) Inattention and (C.) Disorganized Thinking : the resident was coded as 1 indicating the behavior is continuously present and does not fluctuate. Under Section G Functional Status Resident #3 was coded as requiring extensive two person assistance for bed mobility and extensive one person assistance for transfers. Under Section P. Restraints, the resident was coded a 0 indicating a trunk or limb restraint or a chair that prevents rising had not been used on the resident.

Resident #3's Comprehensive Plan of Care was reviewed and documented in part, as follow:

Focus: (Name of Resident #3) is at risk for falls/impaired safety. Date imitated: 4/7/16. Revision: on 2/21/17.

Interventions:
*1/18/17 Anti thrust cushion to WC (wheelchair) with bilateral leg cushions. Date imitated: 1/18/17. Revision on: 2/21/17.
*11/1/16 Bed sensor, chair sensor, concave mattress, fall mat, door alarm, drop seat in the w/c (wheelchair), bed in lowest position. Date imitated: 4/7/16. Revision on: 2/21/17.

Focus: (Name of Resident #3) has Altered Cognition and continues to have the potential for decline R/T (related to) DX (diagnosis) of dementia. Date imitated: 4/7/16. Revision on:2/21/17.

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F 157	Continued From page 9 Interventions: *Approach in a calmer manner. Date imitated: 4/7/16. Focus: Chronic/progressive decline in intellectual functioning characterized by deficit in memory, judgement, decision making and thought process related to Dementia. Dated Imitated: 5/17/16. Revision on: 5/17/16. Interventions: *Anticipate needs and observe for non-verbal cues. Dated Imitated: 5/17/16. *Be patient with resident. Dated Imitated: 5/17/16. *Gently redirect when resident makes inappropriate actions. Dated Imitated: 5/17/16. Focus: (Name) Resident #3 continues to have the potential to demonstrate physical behaviors. (Name) Resident #3 has a hx (history) of being combative with staff. Date Imitated: 2/13/17. Revision on: 2/21/17. Interventions: *Document observed behavior and attempted interventions in behavior log. Date imitated: 2/13/16. Revision on: 2/13/16. *Modify environment to make the resident more comfortable, relaxed, etc. as needed. Date imitated: 2/13/17. Revision on: 2/13/17. *Monitor/document/report to MD (medical doctor) of danger to self and others. Date imitated: 1/24/17. *When the resident becomes agitated: intervene when necessary before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.	F 157		

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F 157	Continued From page 10 Date imitated: 2/13/17. Revision on: 2/21/17. On 2/21/17 at 9:15 a.m. an interview was conducted with CNA #1 (Certified Nursing Assistant) who works the 3-11 shift regarding a complaint the State Survey Agency had received about a particular resident being restrained. During the interview CNA #1 was asked if she had witnessed any other residents being restrained in the facility. CNA #1 stated, " Yes, in the past couple of months (Name of Resident #3) with a gait belt. When I have a break I walk around the halls. She (Resident #3) was sitting in the hallway in a wheelchair by the nurse's station with a gait belt around her, she is another one that is up and down and becomes combative easily." The surveyor asked, "Who was the nurse taking care of the resident that night?" CNA #1 stated, "(Name of LPN #2) (Licensed Practical Nurse). The surveyor asked CNA #1 if restraining a resident was a form of abuse. CNA #1 stated, "Yes, I should have stopped and reported it." The surveyor then asked CNA #1 if she had recently had training on abuse. CNA #1 stated, "We had training on restraints but not abuse." On 2/21/17 at 2:15 p.m. a phone interview was conducted with CNA #3 regarding a complaint the State Survey Agency had received about a particular resident being restrained. During the interview CNA #3 was asked if she had witnessed any other residents being restrained in the facility. CNA #3 stated, "(Name of Resident #3) sometimes with a gait belt because we are always short and she falls." The surveyor asked when was the last time she saw Resident #3 restrained. CNA #3 stated. "In the last month or two and once in a blue moon. We can't keep an eye on her while we are changing people. When	F 157		

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she is in bed she is ok, but when she is up she can be a violent lady. The surveyor asked, "Is it abuse to restrain a resident?" CNA #3 stated, "For me it's not, it is for her safety, better than to bust their head open."

On 2/21/17 at 2:50 p.m. an interview was conducted with LPN #2 who works the 3-11 shift regarding a complaint the State Survey Agency had received about a particular resident being restrained. During the interview LPN #2 was asked if she had witnessed any other residents being restrained. LPN #2 stated, "Yes, (Name of Resident #3) about a month ago with a gait belt in her wheelchair. She is restrained quite often, she gets real combative and combative with others." The Surveyor asked, "What else could have been for the resident instead of restraining her?" LPN #2 stated, "They could have looked at the care plan for interventions like a lap-buddy, alarms, walking her, or toileting her." The surveyor then asked, "Have you ever restrained (Name of Resident #3)?" LPN #2 stated, "Yes, I have restrained her about a month ago with a gait belt." The surveyor asked, "Do you remember what day you actually restrained the resident?" LPN #2 stated, "It was in January like the 9th or 24th. I think it was January the 9th because there was not enough staff to keep my other patients safe." The surveyor asked LPN #2 if Resident #3's physician had been notified by her on January 9th that Resident #3 had been restrained and if an order for the restraint had been obtained from the physician. LPN #2 stated, "No, I did not call the doctor or get an order. I can't remember what she was doing all I remember is that we were short staffed." The surveyor asked LPN #2 if it was abuse to physically restrain a resident. LPN #2 stated, "I don't believe it is. I didn't know what

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else to do, you are under pressure to get your stuff done and understaffed."

LPN #2 's employee file was reviewed and a Written Employee Counseling dated 2/16/17 was identified and documented in part, as follows:

Actions encompassing correction: Failure to follow proper procedure concerning restraints. Understanding resident rights.

Disciplinary action: Written warning. Name (LPN #2) received the facilities restraint policy as well as Resident rights. Name (LPN #2) was re-educated on proper interventions for residents that are a fall risk.

LPN #2 refused to sign the Written Employee Counseling.

On 2/21/17 at 3:15 p.m. a meeting was held with the Administrator, the Director of Nursing (DON) and the Regional Vice President of Operations where the above information was shared regarding Resident #3 being restrained by LPN #2 and witnessed by CNA #1 and CNA #3. The DON stated, "We were not aware she had also been restrained and we will start an investigation immediately."

Resident #3's active and discontinued monthly Physician Orders for January and February 2017 were reviewed. No Physician order was identified as received or discontinued for the use of a restraint for Resident #3.

Resident #3's Medication Administration Record for January and February 2017 were reviewed.

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The review concluded that Resident #3 was under the care of LPN #2 for 13 nights in January and 11 nights in February.

Resident #3's Nurse's Notes 1/9/17 By LPN #2 were reviewed and documented in part, as follows:

1/9/17 at 19:30 (7:30) p.m. Tramadol HCL Tablet 50 mg (milligrams) Give 50 mg by mouth every 4 hours as needed for Pain "My knee's hurt" prn as needed.

1/9/17 at 20:03 (8:03) p.m. Tramadol HCL Tablet 50 mg (milligrams) Give 50 mg by mouth every 4 hours as needed for Pain PRN (as needed) Administration was : Effective.

On 2/21/17 the facility Administrator provided the surveyor a copy of the Facility Reported Incident (FRI) that was faxed to the State Survey Agency regarding Resident #3 being physically restrained documented in part, as follows:

Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: Inappropriate use of restraints.

If applicable, date notification provided to Responsible party, Physician, APS (Adult Protective Services), DHP (Department of Health Professions): all 1/21/17.

On 2/22/17 the facility Administrator provided the surveyor a copy of the Facility Reported Incidents (FRI's) that were faxed to the Virginia Department of Health Professions regarding Resident #3 being physically restrained documented in part,

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as follows:

1. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: Nurse restrained resident with a gait belt to a wheelchair.
Name of employee involved and their position: LPN #2
Employee action initiated or taken: Nurse will have employment terminated.

2. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: LPN did not report seeing a gait belt being used as a restraint on a resident.
Name of employee involved and their position: LPN #4
Employee action initiated or taken: Formal counseling, re-educated on abuse policy.

3. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: CNA did not report seeing a gait belt being used as a restraint on a resident.
Name of employee involved and their position: CNA #3
Employee action initiated or taken: Formal counseling, re-educated on abuse policy.

4. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: LPN did not report seeing a gait belt being used as a restraint on a resident.
Name of employee involved and their position: LPN #1

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Employee action initiated or taken: Formal counseling, re-educated on abuse policy.

On 2/22/17 the Director of Nursing provided the surveyor a copy of her investigation and disciplinary actions regarding Resident #3 being physically restrained with a gait belt which is documented in part, as follows:

Investigation done on reported use of a gait belt as a restraint on (Name of Resident #3).

Spoke to 44 employees from all shifts and departments: No one has ever seen any kind of a restraint on (Name of Resident #3) except the following:

Name LPN #4 stated she had seen (Name of Resident #3) with a gait belt once a month or two ago. I asked if she attempted to remove it or report it and she stated that it wasn't her hall and she didn't want to interfere.

Conclusion: (Name of LPN #4) had knowledge of a resident being restrained but did not witness the restraint being put on.

(Name of LPN #2): suspended, reported to the State Board of Nursing, termination.
(Name of CNA #1): Formal written counseling, work performance monitoring.
(Name of CNA #3): Formal written counseling, work performance monitoring.
(Name of LPN #4): Formal written counseling, work performance monitoring.

On 4/22/17 at 3:10 p.m. a phone interview was conducted with LPN #4 regarding her statement to the Director of Nursing that she had witnessed

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Resident #3 being physically restrained with a gait belt. LPN #4 was asked to explain what she had witnessed regarding Resident #3 being physically restrained. LPN #4 stated, "I saw (Name of Resident #3) restrained about a month ago. She was restrained with a gait belt in her wheelchair in the doorway of her room. I thought to myself wow! I got distracted on my own side and forgot about it because I was trying to take care of my residents too." The surveyor asked, "Did you try to remove the restraint or report it?" LPN #4 stated, "No, I did not." The surveyor asked, "At the time you saw her restrained did you think it was abuse?" LPN #4 stated, 'Well yes and no, because she has fallen so many times." The surveyor asked, "Is physically restraining a resident abuse and are you a mandated reporter of abuse?" LPN #4 stated, "It is abuse no doubt about it and yes I'm a mandated reporter."

Resident #3's Nurse's Note dated 2/21/17 at 14:15 (2:15) p.m. by the Director of Nursing informing the resident's daughter of her mother being physically restrained by a gait belt is documented in part, as follows:

Call placed to (Name of Resident #3's daughter) to notify her that an employee applied a gait belt to prevent resident from rising up out of her w/c and falling. I explained that this was non-compliance of our operating procedures and policies and it was being investigated. Because of the non-compliance the Department of Health was also notified. (Name of Resident #3's daughter) did not have any further question. (Name of Resident #3's Attending Physician) was also notified.

Resident #3's Nurse's Note dated 2/22/17 at

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15:48 (3:48) p.m. by the Administrator informing the resident's daughter of her mother being physically restrained by a gait belt is documented in part, as follows:

Spoke with resident's daughter, Emergency Contact about the findings of the investigation completed by the facility in regards to the gait belt restraint. Informed daughter that the investigation found that the resident was abused. Reiterated that her mother had no physical injuries. Informed her that staff involved will no longer work at the facility. Informed her if she had concerns or questions to please contact me at the facility.

On 2/23/17 at 2:30 p.m. a phone interview was conducted with Resident #3's Attending Physician regarding the resident being physically restrained with a gait belt on 1/9/17. Resident #3's Attending Physician was asked if he was called and consulted with on the night the resident was physically restrained with a gait belt. The Attending Physician stated, "Yesterday was the first I heard of her being restrained. I didn't think we even restrained residents anymore. I would have expected them to call me if she was having a change in her condition, but I would not have given an order for a restraint."

The facility "Code of Conduct" updated 11/21/16 documented in part, as follows:

Legal Responsibilities:

Licensure and Certification: All employees must comply with licensure and certification laws applicable to the operation of the facility.

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The facility policy titled "Virginia Resident Abuse Policy" last revised 2/21/17 is documented in part, as follows:

Policy:
This facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone.

Definitions:

Abuse- Includes actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, mental abuse including abuse facilitated or enabled through the use of technology, misappropriation of resident property, exploitation, involuntary seclusion and injuries of unknown source, physical and chemical restraints.

(*Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury.)

Restraints: (physical or chemical)-may only be used per MD order and in compliance with regulations and guidelines of Fall Prevention and Management Policy and Procedure.

Procedure:

3) Prevention and Identification

Facility's procedures will include:
f. The deployment of staff on each shift in sufficient numbers to meet the needs of the

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residents, and assure that the staff assigned have knowledge of the individual residents' care needs.

The facility policy titled "Restraints" last revised 7/2015 is documented in part, as follows:

Policy:
Physical and/or chemical restraints will be initiated only after a comprehensive review determines that they are necessary to treat the resident's medical symptoms that warrant their use.

Definitions:
Physical Restraint-any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

Procedure: Physical Restraints

A) Using the Restraint Decision Tree (Form 3.40) determine if the device restricts the residents freedom of movement.
2. If the device restricts freedom of movement it is a restraint.

B) If the device restricts freedom of movement it is a restraint. Before proceeding with the device the interdisciplinary team:
1. Evaluates factors leading to the consideration of the device.
2. Determine that all the resident's needs are being met and the need to restrain is not due to unmet needs.
3. Determines that all alternative measures have been attempted and found to be

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unsuccessful.

4. Weighs the risks versus benefits of the restraint being considered.

5. Involve resident and family in decision making and educate those regarding risks and benefits.

6. Analyze all information and decide which is device most appropriate.

a. What has happened/or is happening to the resident.

b. When is the need occurring?

c. What is the cause?

d. What interventions have been tried?

e. Why didn't previous interventions work?

f. What is the least restrictive device?

g. Will it enhance resident's quality of life?

C) Physician order must be obtained that specifies type of restraint, reason for use, and the duration of the restraint.

D) Resident's responsible party will be educated on risk and benefits of device and sign the Informed Consent for Use of Restraints (Form 3.41).

On 2/23/17 at 3:20 p.m. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Compliance Nurse, and the Regional Vice-President of Operations where the above information was shared. The surveyor asked the Director of Nursing what she would have expected for her staff to do instead of restraining the resident. The Director of Nursing stated, "I would have expected them to redirect her, gotten her up and walked her, to document her behavior, to notify the doctor, and if staff see

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F 157	Continued From page 21 someone restrained to take it off and report it." The Regional Vice-President of Operations stated, "We are not happy with the way the residents were treated at all. All we can do is move forward from here." Prior to exit no further information was shared. (1) Psychosis: any major mental disorder of organic or emotional origin characterized by a gross impairment in reality testing, in which the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect references about external reality, even in the face of contrary evidence. (2) Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses. (3) Depression: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	F 157		
F 221 SS=E	This is a COMPLAINT DEFICIENCY RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity.	F 221		3/17/17

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F 221	Continued From page 22 The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to ensure 2 of 10 residents in the survey sample, Resident #1 and #3, were treated with respect and dignity to attain or maintain his/her highest practicable well-being in an environment that	F 221	F-221 1. Res. # 1 & 3 were physically examined to ensure no physical restraint is being used. 2. All residents are at risk for this issue. 3.A In-service for all departments on Resident□s Rights and amended	

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F 221	Continued From page 23 prohibited the use of physical restraints for convenience, and not required to treat the resident's medical symptoms. The State Survey Agency received an anonymous complaint on February 15, 2017 that alleged a resident had been left in a chair restrained all day and overnight. The resident identified in the complaint was Resident #1. As a result of the complaint investigation conducted by this State Survey Agency it was found that the facility staff imposed a physical restraint (a gait belt) for purposes of staff convenience for two residents (Residents #1 and #3). 1. The facility staff failed to ensure that Resident #1 was treated with dignity and respect to include the right to be free from a physical restraint of a gait belt imposed on February 9, 2017 for the purpose of staff convenience for approximately 14 hours. 2. The facility staff failed to ensure that Resident #3 was treated with dignity and respect to include the right to be free from a physical restraint of a gait belt imposed on January 9th, 2017 for the purpose of staff convenience. The findings included: 1. Resident #1 was originally admitted to the facility on 12/23/16 and readmitted on 1/4/17 following a short hospital stay from 12/28/16 through 1/4/17 for acute urinary retention (1). Diagnoses included BPH (benign prostatic hyperplasia), and Alzheimer's dementia.	F 221	Abuse and Prevention Policy to include: - being free from abuse and restraints - be treated with dignity and respect 3. B Facility implemented a physical audit/exam of monitor that no physical residents 5 x per week to restraints are in use. 4 A. During resident council, residents will be asked if they have any concerns regarding being treated with dignity and/or respect. 4 B Audits noted above will continue M-F randomly on all shifts for the next 60 days. 4 C Audit results will be shared in QAPI meetings. It will be determined at the QAPI meeting if the audits are to continue past 60 days. 5. 3/17/17	

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The current MDS (Minimum Data Set) a 30 day with an assessment reference date (ARD) of 1/31/17 coded the resident as scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status), indicating the resident had severely impaired daily decision making skills. The resident was coded as having inattention and disorganized thinking. The resident did not exhibit any behaviors. The resident was able to walk between locations in his/her room and in the corridor on the unit with limited assistance of one staff. Mobility devices used were a walker and wheelchair. The resident had a Foley catheter for bladder drainage. Under Section J. 1800 Fall history coded the resident as not having any falls since Admission/Entry or Reentry or Prior Assessment. This was inaccurate as the clinical record and the comprehensive Resident Centered Plan of Care evidenced the resident had a fall on 1/8/17 which is prior to the ARD.

The Resident Centered Plan of Care initiated 12/24/16 evidenced the resident was identified as at risk for falls/impaired safety related to confusion related to Alzheimer's dementia, poor vision related to glaucoma, history of chronic leg ulcers and debility. Fall on 1/8/17 and fall on 2/9/17. The goal was the resident will not sustain an injury due to a fall through review. Interventions listed to prevent falls and promote safety did not include the use of a physical restraint. The facility failed to follow a systematic process of evaluation and care planning prior to using a physical restraint.

An initial tour of the facility was conducted from 2:30 am to 3:00 am, on 2/21/17. During the initial tour of the facility all residents were observed in their beds asleep, to include Resident #1.

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A night shift nurse (Licensed Practical Nurse/ LPN #3) working on the East unit where Resident #1's room was located was interviewed at 3:00 am. She was asked if she was aware of any allegations of a resident having been restrained to a wheelchair. She stated, "Yes, (name of Resident #1)". She was asked about the circumstances for the use of the restraint. She stated, "He had fallen earlier in the shift (3-11 pm shift), when I arrived to work he had a gait belt on...it was buckled behind the wheelchair, he was behind the nurses station in the wheelchair, he stayed up all night (a nurses station), periodically would be asked if he wanted to go back to bed...he was alert with confusion...he sat quietly, did not try to fight the restraint. When asked why the restraint was not removed, she stated, "Out of sight out of mind". She stated she had asked the CNA (Certified Nurse Aide/CNA#3) assigned to the resident to remove the gait belt and place the resident to bed at approximately 5:00 am.

LPN #3 was asked if she was the one who initiated the gait belt restraint she stated, "No", she repeated that it had been placed on the resident by the 3-11 shift, she did not know exactly who placed the restraint on the resident. When asked as a Mandated Reporter what should you have done? Her response was "Report it to the DON (Director of Nursing)". LPN#3 stated she was suspended for three days (2/10/17-2/12/17), inserviced and given a copy of the abuse and restraint policy.

The gait belt was buckled in the back of the wheelchair; therefore, the resident could not remove at will, which restricted freedom of movement. LPN #3 failed to remove the gait belt,

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failed to stop the abuse, and failed to report the abuse to the DON.

On 2/21/17 at 3:20 am, the Director of Nursing (DON) was interviewed about the allegation of Resident #1 being restrained with a gait belt. While in the DON's office this surveyor was provided with a copy of a facility's investigation report of this allegation dated 2/10/17. This report noted Resident #1 "was found with a gait belt restraining him to the chair". The DON was asked if the Physician and the Resident Representative were notified by the facility that a gait belt was used to restrain Resident #1, she stated, "No". The DON was asked if a FRI (Facility Reportable Incident) had been sent to the State Survey Agency for this incident. She stated, "No". Her response was that she did not consider this abuse as there was "no harm". She stated the staff failed to follow the facility's restraint policy. The DON stated she was made aware of the restraint when the Rehab Director wheeled the resident to her office between 10-10:30 am on 2/10/17. The resident had a gait belt around his waist that was buckled in the back of the wheelchair.

The investigation report included interviews with seven (7) staff who had worked the 3-11 pm shift and the night shift on 2/9/17. The interviews with the Licensed Practical Nurses were as follows:
1. 11-7 pm night shift LPN #3 (Licensed Practical Nurse)- She knew (Resident #1) had a gait belt on from 3-11 and meant to remove it. She said it had been put on him because of a fall he had on 2/9/17. She kept him at the nurses with her. She said that she had told the CNA (Certified Nurse Aide) (name) to take it off before the end of the shift.

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2. 3-11 pm LPN #2- She said Yes she had helped the nurse (LPN#1) locate a gait belt after the resident had a fall at 8 pm. She did not think there was anything wrong with keeping the resident from falling. She stated there were only 4 aides (CNAs-Certified Nurse Aides).
3. 3-11 pm LPN #1 (assigned to care for Resident #1)- She said that (LPN#2) put the gait belt on him and that since she hadn't been a nurse as long as (LPN#2) she didn't think anything about it. She wanted to keep him from falling again since there was so much paperwork with a fall.
The CNA interviews by the DON investigation were as follows:
4. 3-11 pm CNA #1 assigned to Resident #1: She said the resident slid from his bed and that he often was up and down in his room. She did know about the gait belt the nurses put on him. She knew it was wrong but was uncomfortable saying anything to the charge nurse. The resident was not agitated or uncomfortable.
5. 11-7 pm CNA- She did not have any information r/t (related to) the night before.
6. 7-3 am CNA assigned to the resident on 2/10/17- She had not done any care on him when spoken because he had been resistant. He had been in the chair when she came on the shift. She did not notice any gait belt in place.
7. RN Supervisor 3-11 pm-Stated she only knew about the fall but did not know about the gait belt.

On 2/21/17 at 4:00 am, the Administrator was interviewed. He stated he had instructed the DON to do the investigation. Parties involved were disciplined, write ups were done, re-education, and inservices were conducted. He stated the facility was restraint free, clarifying, "As in we don't use them...we don't use restraints."
The question was asked, "Is the use of a gait belt

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for a restraint abuse?" He stated, "Abuse, no, we considered it not following procedure for gait belt use". When asked if a FRI was sent to the State Survey Agency he stated, "No, because there is no injury involved...". When asked if any of the staff involved with the application of the gait belt restraint were reported to the Board of Health Professions he stated, "No, I did not report it...it was a procedural issue".

The Rehab Manager was interviewed on 2/21/17 at 7:00 am. She stated she was walking past the resident's room and noted he was asleep in the wheelchair. She stated, "I noticed he fell asleep in his wheelchair...that's when I noticed the (gait) belt on the back of his chair, when I saw it was attached to him I pushed him to the DON's office...he was dressed...he did not smell fresh...". When asked about the use of the gait belt for a restraint she stated, "That is not policy...it would be considered a restraint...not a form of abuse...we need to keep him safe...they didn't want him up and down...they didn't follow (restraint) policy...I don't consider it abuse because there was no harm". She stated the DON was upset and immediately removed the gait belt. She stated the staff could have implemented other interventions such as :increase supervision, checking on needs such as toileting, and pain".

An incident report dated 2/9/17 entered at 8:05 pm by LPN #1 noted Resident #1 was observed on both knees on the left side of his bed. The resident was assisted x 2 into his w/c (wheelchair). No injuries noted. The resident was immediately placed at the nurses station for close monitoring. The Physician and the resident Representative (RR) was notified of the fall. The

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resident was alert, oriented to person and confused.

The Physician was contacted via phone on 2/21/17 at 11:00 am. The Physician was asked if the facility had called to obtain an order to restrain the resident, his response was, "No, no one has called me in forever about restraints...whoever does restraints anymore?..."When asked if he was notified that Resident #1 was physically restrained with a gait belt in a wheelchair after notification of a fall on 2/9/17, he stated, "They did not notify me...(him/her) being restrained is news to me". When asked, "Would you have expected them (facility) to inform you after they had been made aware the resident was restrained, he responded, "Yes".

During the survey days the resident was observed in his room in bed, in the activities room in a wheelchair watching TV; there was no restraint noted in use. On 2/23/17 at 11:15 am., the resident was observed awake and resting in bed. The resident was asked if the staff had ever used a gait belt to restrain him to the wheelchair, he stated, "Yes". Further questioning of the incident was met with the resident speaking nonsensical, saying "Are you here for the...the..." and then long pauses followed with inappropriate responses.

Resident #1 was restrained with a gait belt following a fall on the evening of 2/9/17 at approximately 8:00 pm. The resident remained at the nurses station restrained with the gait belt all night. Fourteen hours later, at approximately 10:00-10:30 am on 2/10/17 the Rehab Manager noted the gait belt restraint. The Rehab Manager immediately wheeled the resident to the Director

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of Nursing's office and showed her the restraint. The restraint was immediately removed and the resident was assessed for injury, none was found. A facility investigation was initiated.

The facility's investigation interviews with staff evidenced the restraint was used for convenience to prevent movement and not to treat a medical symptom.

The clinical record and the comprehensive Resident Centered Plan of Care evidenced the facility failed to follow a systematic process of evaluation and care planning prior to using a physical restraint.

The clinical record evidenced the Resident's Representative was not educated on the risk and benefits of (restraint) device; or a signed Informed Consent for Use of Restraints.

The Physician Order Summary Report for Active, Completed, Discontinued date range 1/1/17 through 2/28/17 was reviewed. There were no physician order(s) for the application of a physical restraint, type of restraint, reason for use or the duration of the restraint per the facility restraint policy dated 7/2015.

The facility failed to treat Resident #1 with respect and dignity to attain or maintain his highest practicable well-being in an environment that prohibited the use of physical restraints for convenience, and not required to treat the resident's medical symptoms.

On 2/23/17 at 3:20 p.m. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Compliance Nurse, and

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the Regional Vice-President of Operations where the above information was shared. Surveyor #2 asked, "Is restraining with a gait belt a dignity issue with the reasonable person concept? The DON responded," Restraining with a gait belt is a dignity issue with the reasonable person concept". "It was inappropriate to have a gait belt on as a restraint." The Administrator was asked, "What is it meant to be treated with dignity and respect" The Administrator stated, "How You would want to be treated." The surveyor then asked, "How were the residents failed?" The Administrator stated, "By allowing all of this to happen." The Regional Vice-President of Operations stated, "We are not happy with the way the residents were treated at all. All we can do is move forward from here." Prior to exit no further information was shared.

Facility Policies and Procedures reviewed are as follows:

1). The policy titled "Resident Rights and Facility Responsibilities" last revised 11/16 is documented in part, as follows:
Policy: It is the facility's policy to abide by all resident rights, and to communicate these rights to residents and their designated representatives in a language that they can understand.
3. Resident Right and Facility responsibilities are:
(a) Resident Rights: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.
(1) Dignity, Respect, and Quality of Life: a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes

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maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
(e) Respect and Dignity:
(1) Restraints: The right to be free from any physical or chemical restraints imposed for purposes if disciplined or convenience, and not required to treat the resident's medical symptoms, consistent with 483.12(a)(2).

2). The facility policy titled "Restraints" last revised 7/2015 is documented in part, as follows: Policy: Physical and/or chemical restraints will be initiated only after a comprehensive review determines that they are necessary to treat the resident's medical symptoms that warrant their use.

Definitions: Physical Restraint-any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.
Procedure: Physical Restraints

A) Using the Restraint Decision Tree (Form 3.40) determine if the device restricts the residents freedom of movement.
2. If the device restricts freedom of movement it is a restraint.
B) If the device restricts freedom of movement it is a restraint. Before proceeding with the device the interdisciplinary team:
1. Evaluates factors leading to the consideration of the device.
2. Determine that all the resident's needs are being met and the need to restrain is not due to

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unmet needs.

3. Determines that all alternative measures have been attempted and found to be unsuccessful.

4. Weighs the risks versus benefits of the restraint being considered.

5. Involve resident and family in decision making and educate those regarding risks and benefits.

6. Analyze all information and decide which is device most appropriate.

a. What has happened/or is happening to the resident.

b. When is the need occurring?

c. What is the cause?

d. What interventions have been tried?

e. Why didn't previous interventions work?

f. What is the least restrictive device?

g. Will it enhance resident's quality of life?

C) Physician order must be obtained that specifies type of restraint, reason for use, and the duration of the restraint.

D) Resident's responsible party will be educated on risk and benefits of device and sign the Informed Consent for Use of Restraints (Form 3.41).

Definition:

(1) Urinary retention: A side effect of the bladder not emptying properly. It is a common complication of benign prostatic hyperplasia (BPH).

Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

2. Resident #3 was a 84 year old admitted to the facility on 11/23/14 with diagnoses to include

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Psychosis (1), Dementia (2), Major Depressive Disorder (3).

The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 1/16/17. The Brief Interview for Mental Status (BIMS) was a 3 out of a possible 15 which indicated Resident #3 was severely cognitively impaired and incapable of daily decision making. Under Section C 1310 Delirium: (A.) Acute Onset Mental Status Changes: the resident was coded 0 indicating no, (B.) Inattention and (C.) Disorganized Thinking : the resident was coded as 1 indicating the behavior is continuously present and does not fluctuate. Under Section G Functional Status Resident #3 was coded as requiring extensive two person assistance for bed mobility and extensive one person assistance for transfers. Under Section P Restraints, the resident was coded a 0 indicating a trunk or limb restraint or a chair that prevents rising had not been used on the resident.

Resident #3's Comprehensive Plan of Care was reviewed and documented in part, as follows:

Focus: (Name of Resident #3) is at risk for falls/impaired safety. Date imitated: 4/7/16. Revision: on 2/21/17.

Interventions:
*1/18/17 Anti thrust cushion to WC (wheelchair) with bilateral leg cushions. Date imitated: 1/18/17. Revision on: 2/21/17.
*11/1/16 Bed sensor, chair sensor, concave mattress, fall mat, door alarm, drop seat in the w/c (wheelchair), bed in lowest position. Date imitated: 4/7/16. Revision on: 2/21/17.

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F 221	Continued From page 35 Focus: (Name of Resident #3) has Altered Cognition and continues to have the potential for decline R/T (related to) DX (diagnosis) of dementia. Date imitated: 4/7/16. Revision on:2/21/17. Interventions: *Approach in a calmer manner. Date imitated: 4/7/16. Focus: Chronic/progressive decline in intellectual functioning characterized by deficit in memory, judgement, decision making and thought process related to Dementia. Dated Imitated: 5/17/16. Revision on: 5/17/16. Interventions: *Anticipate needs and observe for non-verbal cues. Dated Imitated: 5/17/16. *Be patient with resident. Dated Imitated: 5/17/16. *Gently redirect when resident makes inappropriate actions. Dated Imitated: 5/17/16. Focus: (Name of Resident #3) continues to have the potential to demonstrate physical behaviors. (Name of Resident #3) has a hx (history) of being combative with staff. Date Imitated: 2/13/17. Revision on: 2/21/17. Interventions: *Document observed behavior and attempted interventions in behavior log. Date imitated: 2/13/16. Revision on: 2/13/16. *Modify environment to make the resident more comfortable, relaxed, etc. as needed. Date imitated: 2/13/17. Revision on: 2/13/17. *Monitor/document/report to MD (medical doctor) of danger to self and others. Date imitated:	F 221		

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1/24/17.
*When the resident becomes agitated: intervene when necessary before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Date imitated: 2/13/17. Revision on: 2/21/17.

On 2/21/17 at 4:00 a.m. an interview was conducted with the Administrator and he was asked if restraining a resident with a gait belt was a form of abuse. The Administrator stated, "No, we consider it not following procedure for gait belt use."

On 2/21/17 at 9:15 a.m. an interview was conducted with CNA #1 (Certified Nursing Assistant) who works the 3-11 shift regarding a complaint the Office of Licensure and Certification had received about a particular resident being restrained. During the interview CNA #1 was asked if she had witnessed any other residents being restrained in the facility. CNA #1 stated, " Yes, in the past couple of months (Name of Resident #3) with a gait belt. When I have a break I walk around the halls. She (Resident #3) was sitting in the hallway in a wheelchair by the nurse's station with a gait belt around her, she is another one that is up and down and becomes combative easily." The surveyor asked, "Who was the nurse taking care of the resident that night?" CNA #1 stated, "(Name of LPN #2) (Licensed Practical Nurse). The surveyor asked CNA #1 if restraining a resident was a form of abuse. CNA #1 stated, "Yes, I should have stopped and reported it." The surveyor then asked CNA #1 if she had recently had training on abuse. CNA #1 stated, "We had training on restraints but not abuse."

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On 2/21/17 at 9:20 a.m. an interview was conducted with the RN (Registered Nurse) 3-11 shift supervisor who was asked about restraints in the facility and if restraining a resident was considered abuse. The RN 3-11 Supervisor stated, "We are a no restraint facility and it depends on the resident. If the resident is trying to harm himself, or slapping their face its not but restraining a resident for convenience is abuse."

On 2/21/17 at 2:15 p.m. a phone interview was conducted with CNA #3 regarding a complaint the State Survey Agency had received about a particular resident being restrained. During the interview CNA #3 was asked if she had witnessed any other residents being restrained in the facility. CNA #3 stated, "(Name of Resident #3) sometimes with a gait belt because we are always short and she falls." The surveyor asked when was the last time she saw Resident #3 restrained. CNA #3 stated. "In the last month or two and once in a blue moon. We can't keep an eye on her while we are changing people. When she is in bed she is ok, but when she is up she can be a violent lady. The surveyor asked, "Is it abuse to restrain a resident?" CNA #3 stated, "For me it's not, it is for her safety, better than to bust their head open."

On 2/21/17 at 2:50 p.m. an interview was conducted with LPN #2 who works the 3-11 shift regarding a complaint the State Survey Agency had received about a particular resident being restrained. During the interview LPN #2 was asked if she had witnessed any other residents being restrained. LPN #2 stated, "Yes, (Name of Resident #3) about a month ago with a gait belt in her wheelchair. She is restrained quite often, she

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gets real combative and combative with others." The Surveyor asked, "What else could have been for the resident instead of restraining her?" LPN #2 stated, "They could have looked at the care plan for interventions like a lap-buddy, alarms, walking her, or toileting her." The surveyor then asked, "Have you ever restrained (Name of Resident #3)?" LPN #2 stated, "Yes, I have restrained her about a month ago with a gait belt." The surveyor asked, "Do you remember what day you actually restrained the resident?" LPN #2 stated, "It was in January like the 9th or 24th. I think it was January the 9th because there was not enough staff to keep my other patients safe." The surveyor asked LPN #2 if Resident #3's physician had been notified by her on January 9th that Resident #3 had been restrained and if an order for the restraint had been obtained from the physician. LPN #2 stated, "No, I did not call the doctor or get an order. I can't remember what she was doing all I remember is that we were short staffed." The surveyor asked LPN #2 if it was abuse to physically restrain a resident. LPN #2 stated, "I don't believe it is. I didn't know what else to do, you are under pressure to get your stuff done and understaffed."

LPN #2 's employee file was reviewed and a Written Employee Counseling dated 2/16/17 was identified and documented in part, as follows:

Actions encompassing correction: Failure to follow proper procedure concerning restraints. Understanding resident rights.

Disciplinary action: Written warning. (Name of LPN #2) received the facilities restraint policy as well as Resident rights. (Name of LPN #2) was re-educated on proper interventions for residents

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that are a fall risk.

LPN #2 refused to sign the Written Employee Counseling.

On 2/21/17 at 3:15 p.m. a meeting was held with the Administrator, the Director of Nursing (DON) and the Regional Vice President of Operations where the above information was shared regarding Resident #3 being restrained by LPN #2 and witnessed by CNA #1 and CNA #3. The DON stated, "We were not aware she had also been restrained and we will start an investigation immediately."

Resident #3's active and discontinued monthly Physician Orders for January and February 2017 were reviewed. No Physician order was identified as received or discontinued for the use of a restraint for Resident #3.

Resident #3's Medication Administration Record for January and February 2017 were reviewed. The review concluded that Resident #3 was under the care of LPN #2 for 13 nights in January and 11 nights in February.

Resident #3's Nurse's Notes 1/9/17 by LPN #2 were reviewed and documented in part, as follows:

1/9/17 at 19:30 (7:30) p.m. Tramadol HCL Tablet 50 mg (milligrams) Give 50 mg by mouth every 4 hours as needed for Pain "My knee's hurt" prn as needed.

1/9/17 at 20:03 (8:03) p.m. Tramadol HCL Tablet 50 mg (milligrams) Give 50 mg by mouth every 4 hours as needed for Pain PRN (as needed)

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Administration was : Effective.

On 2/21/17 the facility Administrator provided the surveyor a copy of the Facility Reported Incident (FRI) that was faxed to the Virginia Department of Health Office of Licensure and Certification regarding Resident #3 being physically restrained documented in part, as follows:

Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: Inappropriate use of restraints.

If applicable, date notification provided to Responsible party, Physician, APS (Adult Protective Services), DHP (Department of Health Professionals): all 2/21/17.

On 2/22/17 the facility Administrator provided the surveyor a copy of the Facility Reported Incidents (FRIs) that were faxed to the Virginia Department of Health Professions regarding Resident #3 being physically restrained documented in part, as follows:

1. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: Nurse restrained resident with a gait belt to a wheelchair.
Name of employee involved and their position: LPN #2
Employee action initiated or taken: Nurse will have employment terminated.

2. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action

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taken: LPN did not report seeing a gait belt being used as a restraint on a resident.
Name of employee involved and their position: LPN #4
Employee action initiated or taken: Formal counseling, re-educated on abuse policy.

3. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: CNA did not report seeing a gait belt being used as a restraint on a resident.
Name of employee involved and their position: CNA #3
Employee action initiated or taken: Formal counseling, re-educated on abuse policy.

4. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: LPN did not report seeing a gait belt being used as a restraint on a resident.
Name of employee involved and their position: LPN #1
Employee action initiated or taken: Formal counseling, re-educated on abuse policy.

On 2/22/17 the Director of Nursing provided the surveyor a copy of her investigation and disciplinary actions regarding Resident #3 being physically restrained with a gait belt which is documented in part, as follows:

Investigation done on reported use of a gait belt as a restraint on Name (Resident #3).

Spoke to 44 employees from all shifts and departments: No one has ever seen any kind of a restraint on (Name of Resident #3) except the

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following:

(Name of LPN #4) stated she had seen (Name of Resident #3) with a gait belt once a month or two ago. I asked if she attempted to remove it or report it and she stated that it wasn't her hall and she didn't want to interfere.

Conclusion: (Name of LPN #4) had knowledge of a resident being restrained but did not witness the restraint being put on.

(Name of LPN #2): suspended, reported to the State Board of Nursing, termination.
(Name of CNA #1): Formal written counseling, work performance monitoring.
(Name of CNA #3): Formal written counseling, work performance monitoring.
(Name of LPN #4): Formal written counseling, work performance monitoring.

On 4/22/17 at 3:10 p.m. a phone interview was conducted with LPN #4 regarding her statement to the Director of Nursing that she had witnessed Resident #3 being physically restrained with a gait belt. LPN #4 was asked to explain what she had witnessed regarding Resident #3 being physically restrained. LPN #4 stated, "I saw (Name of Resident #3) restrained about a month ago. She was restrained with a gait belt in her wheelchair in the doorway of her room. I thought to myself wow! I got distracted on my own side and forgot about it because I was trying to take care of my residents too." The surveyor asked, "Did you try to remove the restraint or report it?" LPN #4 stated, "No, I did not." The surveyor asked, "At the time you saw her restrained did you think it was abuse?" LPN #4 stated, 'Well yes and no, because she has fallen so many times." The

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surveyor asked, "Is physically restraining a resident abuse and are you a mandated reporter of abuse?" LPN #4 stated, "It is abuse no doubt about it and yes I'm a mandated reporter."

Resident #3's Nurse's Note dated 2/21/17 at 14:15(2:15) p.m. by the Director of Nursing informing the resident's daughter of her mother being physically restrained by a gait belt is documented in part, as follows:

Call placed to (Name of Resident #3's daughter) to notify her that an employee applied a gait belt to prevent resident from rising up out of her w/c and falling. I explained that this was non-compliance of our operating procedures and policies and it was being investigated. Because of the non-compliance the Department of Health was also notified. (Name of Resident #3's daughter) did not have any further question. (Name of Resident #3's Attending Physician) was also notified.

Resident #3's Nurse's Note dated 2/22/17 at 15:48 (3:48) p.m. by the Administrator informing the resident's daughter of her mother being physically restrained by a gait belt is documented in part, as follows:

"Spoke with resident's daughter, Emergency Contact about the findings of the investigation completed by the facility in regards to the gait belt restraint. Informed daughter that the investigation found that the resident was abused. Reiterated that her mother had no physical injuries. Informed her that staff involved will no longer work at the facility. Informed her if she had concerns or questions to please contact me at the facility."

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On 2/23/17 at 2:30 p.m. a phone interview was conducted with Resident #3's Attending Physician regarding the resident being physically restrained with a gait belt on 1/9/17. Resident #3's Attending Physician was asked if he was called and consulted with on the night the resident was physically restrained with a gait belt. The Attending Physician stated, "Yesterday was the first I heard of her being restrained. I didn't think we even restrained residents anymore. I would have expected them to call me if she was having a change in her condition, but I would not have given an order for a restraint."

The facility "Code of Conduct" updated 11/21/16 documented in part, as follows:

Legal Responsibilities:

Fraud and Abuse: Any employee who suspects a fraud and abuse issue is required to promptly report it to their supervisor. If the employee is not comfortable reporting the issue to their supervisor, the employee may report it to the Chief Compliance Officer.

Licensure and Certification: All employees must comply with licensure and certification laws applicable to the operation of the facility.

The facility policy titled "Virginia Resident Abuse Policy" last revised 2/21/17 is documented in part, as follows:

Policy:
This facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone.

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F 221	Continued From page 45 Definitions: Abuse- Includes actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, mental abuse including abuse facilitated or enabled through the use of technology, misappropriation of resident property, exploitation, involuntary seclusion and injuries of unknown source, physical and chemical restraints. (*Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury.) Restraints: (physical or chemical)-may only be used per MD order and in compliance with regulations and guidelines of Fall Prevention and Management Policy and Procedure. Procedure: 3) Prevention and Identification Facility's procedures will include: f. The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs. The facility policy titled "Restraints" last revised 7/2015 is documented in part, as follows: Policy: Physical and/or chemical restraints will be	F 221		

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initiated only after a comprehensive review determines that they are necessary to treat the resident's medical symptoms that warrant their use.

Definitions:
Physical Restraint-any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

Procedure: Physical Restraints

A) Using the Restraint Decision Tree (Form 3.40) determine if the device restricts the residents freedom of movement.
2. If the device restricts freedom of movement it is a restraint.

B) If the device restricts freedom of movement it is a restraint. Before proceeding with the device the interdisciplinary team:
1. Evaluates factors leading to the consideration of the device.
2. Determine that all the resident's needs are being met and the need to restrain is not due to unmet needs.
3. Determines that all alternative measures have been attempted and found to be unsuccessful.
4. Weighs the risks versus benefits of the restraint being considered.
5. Involve resident and family in decision making and educate those regarding risks and benefits.
6. Analyze all information and decide which is device most appropriate.

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a. What has happened/or is happening to the resident.
b. When is the need occurring?
c. What is the cause?
d. What interventions have been tried?
e. Why didn't previous interventions work?
f. What is the least restrictive device?
g. Will it enhance resident's quality of life?

C) Physician order must be obtained that specifies type of restraint, reason for use, and the duration of the restraint.

D) Resident's responsible party will be educated on risk and benefits of device and sign the Informed Consent for Use of Restraints (Form 3.41).

The facility policy titled "Resident Rights and Facility Responsibilities" last revised 11/16 is documented in part, as follows:

Policy: It is the facility's policy to abide by all resident rights, and to communicate these rights to residents and their designated representatives in a language that they can understand.

3. Resident Right and Facility responsibilities are:
(a) Resident Rights: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.
(1) Dignity, Respect, and Quality of Life: a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes

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maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

(e) Respect and Dignity:
(1) Restraints: The right to be free from any physical or chemical restraints imposed for purposes if disciplined or convenience, and not required to treat the resident's medical symptoms, consistent with 483.12(a)(2).

On 2/23/17 at 3:20 p.m. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Compliance Nurse, and the Regional Vice-President of Operations where the above information was shared. The surveyor asked the Administrator if a resident is chemically or physically restrained to prevent movement without injury or harm, is this abuse. The Administrator stated, "At this time yes, going through the process of this and rewriting the abuse policy it is considered abuse." The Director of Nursing was asked if she would have expected her staff to come forward as mandated reporters when they saw Resident #3 restrained. The Director of Nursing stated, "Yes, absolutely. Restraining with a gait belt is a dignity issue with the reasonable person concept. It was inappropriate to have a gait belt on as a restraint." The surveyor asked the Director of Nursing what she would have expected for her staff to do instead of restraining the resident. The Director of Nursing stated, "I would have expected them to redirect her, gotten her up and walked her, to document her behavior, to notify the doctor, and if staff see someone restrained to take it off and report it." The Administrator was asked, "What is it meant to be treated with dignity and respect?"

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F 221	Continued From page 49 The Administrator stated, "How You would want to be treated." The surveyor then asked, "How were the residents failed?" The Administrator stated, "By allowing all of this to happen." The Regional Vice-President of Operations stated, "We are not happy with the way the residents were treated at all. All we can do is move forward from here." Prior to exit no further information was shared. (1) Psychosis: any major mental disorder of organic or emotional origin characterized by a gross impairment in reality testing, in which the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect references about external reality, even in the face of contrary evidence. (2) Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses. (3) Depression: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	F 221		
F 223 SS=E	This is a COMPLAINT DEFICIENCY FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1)	F 223		3/17/17

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F 223	Continued From page 50 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to ensure 2 of 10 residents in the survey sample, Resident #1 and #3, were free from abuse by use of a physical restraint not required to treat the resident's medical symptoms. The State Survey Agency received an anonymous complaint on February 15, 2017 that alleged a resident had been left in a chair restrained all day and overnight. The resident identified in the complaint was Resident #1. As a result of the complaint investigation conducted by this State Survey Agency it was founded that the facility staff imposed a physical restraint (a gait belt) not required to treat resident medical symptoms for two residents (Residents #1 and #3). 1. The facility staff failed to ensure that Resident #1 was free from abuse by the use of a physical	F 223	F-223 1 A Res. # 1 & 3 were physically examined to ensure no physical restraint is being use 1 B Facility Abuse Policy was revised to include the use of restraints. 2. All residents are at risk for this issue. 3 A Inservice provided to current staff on amended Abuse Policy by members of the Management Staff. 3 B Inservice for the DON on investigation of allegations of abuse by the Reg. Vice President of Operations. 3 C Facility will provide sufficient staff to meet the needs of the residents. 3 D Facility implemented a physical audit/exam of residents 5 x per week to monitor that no physical restraints are in use. 4 A The above audit will be performed 5x weekly randomly on all shifts to ensure restraints are not in use. 4 B Any allegation of abuse will be	

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F 223	Continued From page 51 restraint (a gait belt) on February 9, 2017. The physical restraint was used to prevent movement, and not required to treat the resident's symptoms. Resident #1 was restrained in a wheelchair with a gait belt for approximately 14 hours from 8:00 pm until 10-10:30 am the following morning of February 10, 2017. 2. The facility staff failed to ensure that Resident #3 was free from abuse by use of a physical restraint (a gait belt) in January 2017,to prevent movement, that was not required to treat the resident's symptoms. The findings included: 1. Resident #1 was originally admitted to the facility on 12/23/16 and readmitted on 1/4/17 following a short hospital stay from 12/28/16 through 1/4/17 for acute urinary retention (1). Diagnoses included BPH (benign prostatic hyperplasia), and Alzheimer's dementia. The current MDS (Minimum Data Set) a 30 day with an assessment reference date (ARD) of 1/31/17 coded the resident as scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status), indicating the resident had severely impaired daily decision making skills. The resident was coded as having inattention and disorganized thinking. The resident did not exhibit any behaviors. The resident was able to walk between locations in his/her room and in the corridor on the unit with limited assistance of one staff. Mobility devices used were a walker and wheelchair. The resident had a Foley catheter for bladder drainage. Under Section J. 1800 Fall history coded the resident as not having any falls since Admission/Entry or Reentry or Prior	F 223	audited by the Administrator to ensure a thorough investigation is completed. 4 C DON or designee will review the staffing sheets M-F to ensure sufficient staff is scheduled. 4 D All audit results will be shared in QAPI meeting. 5. 3/17/17	

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Assessment. This was inaccurate as the clinical record and the comprehensive Resident Centered Plan of Care evidenced the resident had a fall on 1/8/17 which was prior to the ARD.

The Resident Centered Plan of Care initiated 12/24/16 evidenced the resident was identified as at risk for falls/impaired safety related to confusion related to Alzheimer's dementia, poor vision related to glaucoma, history of chronic leg ulcers and debility. Fall on 1/8/17 and fall on 2/9/17. The goal was the resident will not sustain an injury due to a fall through review. Interventions listed to prevent falls and promote safety did not include the use of a physical restraint.

An initial tour of the facility was conducted from 2:30 am to 3:00 am, on 2/21/17. During the initial tour of the facility all residents were observed in their beds asleep, to include Resident #1.

A night shift nurse (Licensed Practical Nurse/ LPN #3) working on the East unit where Resident #1's room was located was interviewed at 3:00 am. She was asked if she was aware of any allegations of a resident having been restrained to a wheelchair. She stated, "Yes, (name of Resident #1)". She was asked about the circumstances for the use of the restraint. She stated, "He had fallen earlier in the shift (3-11 pm shift), when I arrived to work he had a gait belt on...it was buckled behind the wheelchair, he was behind the nurses station in the wheelchair, he stayed up all night at the nurses station, periodically would be asked if he wanted to go back to bed...he was alert with confusion...he sat quietly, did not try to fight the restraint." When asked why the restraint was not removed, she

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stated, "Out of sight out of mind". She stated she had asked the CNA (Certified Nurse Aide/CNA#3) assigned to the resident to remove the gait belt and place the resident to bed at approximately 5:00 am.

LPN #3 was asked if she was the one who initiated the gait belt restraint she stated, "No", she repeated that it had been placed on the resident by the 3-11 shift, she did not know exactly who placed the restraint on the resident. " When asked as a Mandated Reporter what should you have done? Her response was "Report it to the DON (Director of Nursing)". LPN#3 stated she was suspended for three days (2/10/17-2/12/17), inserviced and given a copy of the abuse and restraint policy.

The gait belt was buckled in the back of the wheelchair therefore the resident could not remove at will, which restricted freedom of movement.

On 2/21/17 at 3:20 am, the Director of Nursing (DON) was interviewed about the allegation of Resident #1 being restrained with a gait belt. While in the DON's office this surveyor was provided with a copy of the facility's investigation report about this allegation dated 2/10/17. This report noted Resident #1 "was found with a gait belt restraining him to the chair". The DON did not obtain written witness statements. The DON was asked if the Physician and the Resident Representative were notified by the facility that a gait belt was used to restrain Resident #1, she stated, "No". The DON was asked if a FRI (Facility Reportable Incident) had been sent to the State Survey Agency for this incident, she stated, "No". When asked why a FRI had not been sent

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her response was that she did not consider this incident as abuse as there was "no harm". She stated the staff failed to follow the facility's restraint policy. The DON stated she was made aware of the restraint when the Rehab Director wheeled the resident to her office between 10-10:30 am on 2/10/17. The resident had a gait belt around his waist that was buckled in the back of the wheelchair.

The investigation report failed to include all staff working the 3-11 pm and 11 pm-7 am shift on the East unit on 2/9/17. Of the ten (10) staffed worked five (5) were interviewed. The 3-11 pm RN Supervisor and the day shift CNA were interviewed. The interviews were as follows:
1. 11-7 pm night shift LPN #3 (Licensed Practical Nurse)- She knew (Resident #1) had a gait belt on from 3-11 and meant to remove it. She said it had been put on him because of a fall he had on 2/9/17. She kept him at the nurses station with her. She said that she had told the CNA (Certified Nurse Aide) (name) to take it off before the end of the shift.
2. 3-11 pm LPN #2- She said Yes she had helped the nurse (LPN #1) locate a gait belt after the resident had a fall at 8 pm. She did not think there was anything wrong with keeping the resident from falling. She stated there were only 4 aides (CNAs-Certified Nurse Aides).
3. 3-11 pm LPN #1 (assigned to care for Resident #1)- She said that (LPN #2) put the gait belt on him and that since she hadn't been a nurse as long as (LPN #2) she didn't think anything about it. She wanted to keep him from falling again since there was so much paperwork with a fall.
4. 3-11 pm CNA #1 assigned to Resident #1: She said the resident slid from his bed and that he often was up and down in his room. She did

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know about the gait belt the nurses put on him. She knew it was wrong but was uncomfortable saying anything to the charge nurse. The resident was not agitated or uncomfortable.
5. 11-7 pm CNA #3- She did not have any information r/t (related to) the night before.
6. 7-3 am CNA #5 assigned to the resident on 2/10/17- She had not done any care on him when spoken because he had been resistant. He had been in the chair when she came on the shift. She did not notice any gait belt in place.
7. RN Supervisor 3-11 pm- Stated she only knew about the fall but did not know about the gait belt.

On 2/21/17 at 4:00 am, the Administrator was interviewed. He stated he had instructed the DON to do the investigation. Parties involved were disciplined, write ups were done, re-education, and inservices were conducted. He stated the facility was restraint free, clarifying, "As in we don't use them...we don't use restraints." The question was asked, "Is the use of a gait belt for a restraint abuse?" He stated, "Abuse, no, we considered it not following procedure for gait belt use". When asked if a FRI was sent to the State Survey Agency he stated, "No, because there is no injury involved...". When asked if any of the staff involved with the application of the gait belt restraint where reported to the Board of Health Professions he stated, "No, I did not report it...it was a procedural issue".

The Rehab Manager was interviewed on 2/21/17 at 7:00 am. She stated she was walking past the resident's room and noted he was asleep in the wheelchair. She stated, "I noticed he fell asleep in his wheelchair...that's when I noticed the (gait) belt on the back of his chair, when I saw it was attached to him I pushed him to the DON's

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office...he was dressed...he did not smell fresh...". When asked about the use of the gait belt for a restraint she stated, "That is not policy...it would be considered a restraint...not a form of abuse...we need to keep him safe...they didn't want him up and down...they didn't follow (restraint) policy...I don't consider it abuse because there was no harm". She stated the DON was upset and immediately removed the gait belt. She stated the staff could have implemented other interventions such as: increase supervision, checking on needs such as toileting, and pain".

An incident report dated 2/9/17 entered at 8:05 pm by LPN #1 noted Resident #1 was observed on both knees on the left side of his bed. The resident was assisted x 2 into his w/c (wheelchair). No injuries noted. The resident was immediately placed at the nurses station for close monitoring. The Physician and the resident Representative (RR) was notified of the fall. The resident was alert, oriented to person and confused.

The Physician was contacted via phone on 2/21/17 at 11:00 am. The Physician was asked if the facility had called to obtain an order to restrain the resident, his response was, "No, no one has called me in forever about restraints...whoever does restraints anymore?..."When asked if he was notified that Resident #1 was physically restrained with a gait belt in a wheelchair after notification of a fall on 2/9/17, he stated, "They did not notify me...(him/her) being restrained is news to me". When asked, "Would you have expected them (facility) to inform you after they had been made aware the resident was restrained, he responded, "Yes".

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CNA #3 was interviewed by phone on 2/21/17 at 2:15 pm. She stated, "He was already in the restraint at the nurses station...3-11 put the restraint on him..." She stated the resident was asked if he wanted to go to bed and stated no. She stated the resident was taken to his room at approximately 3:00 am to empty the Foley drainage bag, the restraint was removed and the resident was placed back at the nurses station. She stated when she finished rounds at approximately 4:00 am, the restraint had been reapplied. She did not know by whom. She stated, "We are always short staffed".

On 2/21/17 at approximately 2:20 pm, LPN#1 was interviewed in person. She stated the resident had a fall during the evening medication pass at approximately 8:00 pm. The resident was found at his bedside on his knees. The resident was placed back into the wheelchair and then placed at the nurses station. She stated, "(name of LPN #2) was at the nurses station...when I went to go give more meds she had put the restraint on him...I had a lot to do with the computer and the fall...I didn't realize it (the gait belt) was tied to the chair...it didn't hit me it was a restraint...When asked if the resident was provided care by CNA #1 after he was placed in the wheelchair and before the next shift came in she stated, "I didn't recall she did". She continued to state that LPN #2 reported to the oncoming nurse (LPN #1) "We have him up here with a belt on". When asked if a restraint with a gait belt was a form of abuse, she stated, "Yes, I have just learned that...".

On 2/21/17 at 2:50 pm, LPN #2 was interviewed in person in the presence of Surveyor #2. Her

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immediate response to explain the circumstances for the use of a gait belt as a restraint for Resident #1 was, "(name of LPN #3) is a liar...the resident was extremely agitated, he had fallen and she bought him to the nurses station...he kept wrapping his Foley catheter around the foot petals...(LPN #3) stated, I wish I had a gait belt...I helped her (LPN #3) put the gait belt on him...in between we tried to care of the other residents...we are always short (staffed)...it got to be a game...just to keep him from falling and pulling out his catheter...I asked (LPN #3) do you want me to take that gait belt off him, she said "No, keep it on him". When asked if the use of the gait belt as a restraint to prevent movement and not to treat a symptom was abuse, she stated, " I don't believe it is...I don't know what else to do...your under pressure to get your stuff done...we were understaffed...". When asked if the physician was called for a restraint order, she stated, "No". When asked if the chain of command (the Administrator, DON, Supervisor) were okay with the use of the gait belt as a restraint she stated, " Yes, because I know the chain of command has seen it...and they haven't said anything". When asked if it was common practice, she stated, "No, it is not".

During the survey days the resident was observed in his room in bed, in the activities room in a wheelchair watching TV, there was no restraint noted in use. On 2/23/17 at 11:15 am., the resident was observed awake and resting in bed. The resident was asked if the staff had ever used a gait belt to restrain him to the wheelchair, he stated, "Yes". Further questioning of the incident was met with the resident speaking nonsensical, saying "Are you here for the...the..." and then long pauses followed with inappropriate

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responses.

The Physician Order Summary Report for Active, Completed, Discontinued date range 1/1/17 through 2/28/17 was reviewed. There were no physician order(s) for the application of a physical restraint, type of restraint, reason for use or the duration of the restraint per the facility restraint policy dated 7/2015.

The facility's investigation interviews with staff evidenced the restraint was deliberately placed on Resident #1 for convenience, to prevent movement, and not to treat a medical symptom. None of the staff that were witnesses to the restraint stopped the abuse or reported it.

The clinical record evidenced the Residents Representative was not educated on the risk and benefits of (restraint) device; or a signed Informed Consent for Use of Restraints.

Review of the Nursing Daily Sheets noted LPN #1 and LPN #2 were not suspended during the investigation, to protect others from harm. LPN #1 worked on 2/12/17. LPN #2 worked on 2/10/, 2/11, and 2/12/17.

The DON failed to thoroughly investigate abuse, report abuse and failed to protect other residents from harm during the investigation.

The facility's Abuse Policy titled "Virginia Resident Abuse Policy" revised 1/19/17 failed to define and address chemical and physical restraints as abuse.

On 2/23/17 at 3:20 p.m. a pre-exit conference

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was conducted with the Administrator, the Director of Nursing, the Compliance Nurse, and the Regional Vice-President of Operations where the above information was shared. Surveyor #2 asked the Administrator if a resident is chemically or physically restrained to prevent movement without injury or harm is this abuse. The Administrator stated, "At this time yes, going through the process of this and rewriting the abuse policy it is considered abuse." The surveyor then asked, "How were the residents failed?" The Administrator stated, "By allowing all of this to happen." The Regional Vice-President of Operations stated, "We are not happy with the way the residents were treated at all. All we can do is move forward from here." Prior to exit no further information was shared.

As a result of the survey the facility revised their Virginia Resident Abuse Policy to include recognition of chemical and physical restraints as abuse. The revision included: Restraints (physical or chemical)- may only be used per MD order an in compliance with regulations and guidelines of Fall Prevention and Management P&P.

Additional Facility Policies and Procedures reviewed: Include Resident Rights and Facility Responsibilities revised 11/16, and Restraints revised 7/15.

1). Resident Rights and Facility Responsibilities revised 11/16, is documented in part, as follows:
Policy: It is the facility's policy to abide by all resident rights, and to communicate these rights to residents and their designated representatives in a language that they can understand.
3. Resident Right and Facility responsibilities are:

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(a) Resident Rights: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

(1) Dignity, Respect, and Quality of Life: a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

(e) Respect and Dignity:

(1) Restraints: The right to be free from any physical or chemical restraints imposed for purposes if disciplined or convenience, and not required to treat the resident's medical symptoms, consistent with 483.12(a)(2).

2.) "Restraints" is documented in part, as follows:
Policy: Physical and/or chemical restraints will be initiated only after a comprehensive review determines that they are necessary to treat the resident's medical symptoms that warrant their use.
Definitions: Physical Restraint-any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.
Procedure: Physical Restraints
A) Using the Restraint Decision Tree (Form 3.40) determine if the device restricts the residents freedom of movement.
2. If the device restricts freedom of movement it is a restraint.
B) If the device restricts freedom of movement it

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is a restraint. Before proceeding with the device the interdisciplinary team:

1. Evaluates factors leading to the consideration of the device.
2. Determine that all the resident's needs are being met and the need to restrain is not due to unmet needs.
3. Determines that all alternative measures have been attempted and found to be unsuccessful.
4. Weighs the risks versus benefits of the restraint being considered.
5. Involve resident and family in decision making and educate those regarding risks and benefits.
6. Analyze all information and decide which is device most appropriate.
   a. What has happened/or is happening to the resident.
   b. When is the need occurring?
   c. What is the cause?
   d. What interventions have been tried?
   e. Why didn't previous interventions work?
   f. What is the least restrictive device?
   g. Will it enhance resident's quality of life?

C) Physician order must be obtained that specifies type of restraint, reason for use, and the duration of the restraint.

D) Resident's responsible party will be educated on risk and benefits of device and sign the Informed Consent for Use of Restraints (Form 3.41).

3). Virginia Resident Abuse Policy in part, read as follows:

Policy: This facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and

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misappropriation of resident property by anyone.
Definitions:
Abuse- Includes actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, mental abuse including abuse facilitated or enabled through the use of technology, misappropriation of resident property, exploitation, involuntary seclusion and injuries of unknown source, physical and chemical restraints.
(*Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury.)
Restraints: (physical or chemical)-may only be used per MD order and in compliance with regulations and guidelines of Fall Prevention and Management Policy and Procedure.

Procedure:
3) Prevention and Identification-Facility's procedures will include:
f. The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs.

Medical Definitions:
(1) Urinary retention: A side effect of the bladder not emptying properly. It is a common complication of benign prostatic hyperplasia (BPH).
Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

2. The facility staff failed to ensure that Resident

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#3 was free from abuse by allowing the use of a physical restraint to be applied in January 2017 not required to treat the resident's symptoms.

Resident #3 was a 84 year old admitted to the facility on 11/23/14 with diagnoses to include Psychosis (1), Dementia (2), Major Depressive Disorder (3).

The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 1/16/17. The Brief Interview for Mental Status (BIMS) was a 3 out of a possible 15 which indicated Resident #3 was severely cognitively impaired and incapable of daily decision making. Under Section C1310 Delirium: (A.) Acute Onset Mental Status Changes: the resident was coded 0 indicating no, (B.) Inattention and (C.) Disorganized Thinking : the resident was coded as 1 indicating the behavior is continuously present and does not fluctuate. Under Section G Functional Status Resident #3 was coded as requiring extensive two person assistance for bed mobility and extensive one person assistance for transfers. Under Section P Restraints, the resident was coded a 0 indicating a trunk or limb restraint or a chair that prevents rising had not been used on the resident.

Resident #3's Comprehensive Plan of Care was reviewed and documented in part, as follow:

Focus: (Name of Resident #3) is at risk for falls/impaired safety. Date imitated: 4/7/16. Revision: on 2/21/17.

Interventions:
*1/18/17 Anti thrust cushion to WC (wheelchair)

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with bilateral leg cushions. Date imitated: 1/18/17. Revision on: 2/21/17.
*11/1/16 Bed sensor, chair sensor, concave mattress, fall mat, door alarm, drop seat in the w/c (wheelchair), bed in lowest position. Date imitated: 4/7/16. Revision on: 2/21/17.

Focus: (Name of Resident #3) has Altered Cognition and continues to have the potential for decline R/T (related to) DX (diagnosis) of dementia. Date imitated: 4/7/16. Revision on:2/21/17.

Interventions: *Approach in a calmer manner. Date imitated: 4/7/16.

Focus: Chronic/progressive decline in intellectual functioning characterized by deficit in memory, judgement, decision making and thought process related to Dementia. Dated Imitated: 5/17/16. Revision on: 5/17/16.

Interventions:
*Anticipate needs and observe for non-verbal cues. Dated Imitated: 5/17/16.
*Be patient with resident. Dated Imitated: 5/17/16.
*Gently redirect when resident makes inappropriate actions. Dated Imitated: 5/17/16.

Focus: (Name of Resident #3) continues to have the potential to demonstrate physical behaviors. (Name of Resident #3) has a hx (history) of being combative with staff. Date Imitated: 2/13/17. Revision on: 2/21/17.

Interventions:
*Document observed behavior and attempted interventions in behavior log. Date imitated:

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2/13/16. Revision on: 2/13/16.
*Modify environment to make the resident more comfortable, relaxed, etc. as needed. Date imitated: 2/13/17. Revision on: 2/13/17.
*Monitor/document/report to MD (medical doctor) of danger to self and others. Date imitated: 1/24/17.
*When the resident becomes agitated: intervene when necessary before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Date imitated: 2/13/17. Revision on: 2/21/17.

On 2/21/17 at 4:00 a.m. an interview was conducted with the Administrator and he was asked if restraining a resident with a gait belt was a form of abuse. The Administrator stated, "No, we consider it not following procedure for gait belt use."

On 2/21/17 at 9:15 a.m. an interview was conducted with CNA #1 (Certified Nursing Assistant) who works the 3-11 shift regarding a complaint the Office of Licensure and Certification had received about a particular resident being restrained. During the interview CNA #1 was asked if she had witnessed any other residents being restrained in the facility. CNA #1 stated, " Yes, in the past couple of months (Name of Resident #3) with a gait belt. When I have a break I walk around the halls. She (Resident #3) was sitting in the hallway in a wheelchair by the nurse's station with a gait belt around her, she is another one that is up and down and becomes combative easily." The surveyor asked, "Who was the nurse taking care of the resident that night?" CNA #1 stated, "(Name of LPN #2) (Licensed Practical Nurse).

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The surveyor asked CNA #1 if restraining a resident was a form of abuse. CNA #1 stated, "Yes, I should have stopped and reported it." The surveyor then asked CNA #1 if she had recently had training on abuse. CNA #1 stated, "We had training on restraints but not abuse."

On 2/21/17 at 9:20 a.m. an interview was conducted with the RN (Registered Nurse) 3-11 shift supervisor who was asked about restraints in the facility and if restraining a resident was considered abuse. The RN 3-11 Supervisor stated, "We are a no restraint facility and it depends on the resident. If the resident is trying to harm himself, or slapping their face its not but restraining a resident for convenience is abuse."

On 2/21/17 at 2:15 p.m. a phone interview was conducted with CNA #3 regarding a complaint the Office of Licensure and Certification had received about a particular resident being restrained. During the interview CNA #3 was asked if she had witnessed any other residents being restrained in the facility. CNA #3 stated, "(Name of Resident #3) sometimes with a gait belt because we are always short and she falls." The surveyor asked when was the last time she saw Resident #3 restrained. CNA #3 stated. "In the last month or two and once in a blue moon. We can't keep an eye on her while we are changing people. When she is in bed she is ok, but when she is up she can be a violent lady. The surveyor asked, "Is it abuse to restrain a resident?" CNA #3 stated, "For me it's not, it is for her safety, better than to bust their head open."

On 2/21/17 at 2:50 p.m. an interview was conducted with LPN #2 who works the 3-11 shift regarding a complaint the State Survey Agency

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had received about a particular resident being restrained. During the interview LPN #2 was asked if she had witnessed any other residents being restrained. LPN #2 stated, "Yes, (Name of Resident #3) about a month ago with a gait belt in her wheelchair. She is restrained quite often, she gets real combative and combative with others." The Surveyor asked, "What else could have been for the resident instead of restraining her?" LPN #2 stated, "They could have looked at the care plan for interventions like a lap-buddy, alarms, walking her, or toileting her." The surveyor then asked, "Have you ever restrained (Name of Resident #3)?" LPN #2 stated, "Yes, I have restrained her about a month ago with a gait belt." The surveyor asked, "Do you remember what day you actually restrained the resident?" LPN #2 stated, "It was in January like the 9th or 24th. I think it was January the 9th because there was not enough staff to keep my other patients safe." The surveyor asked LPN #2 if Resident #3's physician had been notified by her on January 9th that Resident #3 had been restrained and if an order for the restraint had been obtained from the physician. LPN #2 stated, "No I did not call the doctor or get an order. I can't remember what she was doing all I remember is that we were short staffed." The surveyor asked LPN #2 if it was abuse to physically restrain a resident. LPN #2 stated, "I don't believe it is. I didn't know what else to do, you are under pressure to get your stuff done and understaffed."

LPN #2 's employee file was reviewed and a Written Employee Counseling dated 2/16/17 was identified and documented in part, as follows:

Actions encompassing correction: Failure to follow proper procedure concerning restraints.

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Understanding resident rights.

Disciplinary action: Written warning. (Name of LPN #2) received the facilities restraint policy as well as Resident rights. (Name of LPN #2) was re-educated on proper interventions for residents that are a fall risk.

LPN #2 refused to sign the Written Employee Counseling.

On 2/21/17 at 3:15 p.m. a meeting was held with the Administrator, the Director of Nursing (DON) and the Regional Vice President of Operations where the above information was shared regarding Resident #3 being restrained by LPN #2 and witnessed by CNA #1 and CNA #3. The DON stated, "We were not aware she had also been restrained and we will start an investigation immediately."

Resident #3's active and discontinued monthly Physician Orders for January and February 2017 were reviewed. No Physician order was identified as received or discontinued for the use of a restraint for Resident #3.

Resident #3's Medication Administration Record for January and February 2017 were reviewed. The review concluded that Resident #3 was under the care of LPN #2 for 13 nights in January and 11 nights in February.

Resident #3's Nurse's Notes 1/9/17 By LPN #2 were reviewed and documented in part, as follows:

1/9/17 at 19:30 (7:30) p.m. Tramadol HCL Tablet 50 mg (milligrams) Give 50 mg by mouth every 4

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hours as needed for Pain "My knee's hurt" prn as needed.

1/9/17 at 20:03 (8:03) p.m. Tramadol HCL Tablet 50 mg (milligrams) Give 50 mg by mouth every 4 hours as needed for Pain PRN (as needed) Administration was: Effective.

On 2/21/17 the facility Administrator provided the surveyor a copy of the Facility Reported Incident (FRI) that was faxed to the Virginia Department of Health Office of Licensure and Certification regarding Resident #3 being physically restrained documented in part, as follows:

Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: Inappropriate use of restraints.

If applicable, date notification provided to Responsible party, Physician, APS (Adult Protective Services), DHP (Department of Health Professions): all 2/21/17.

On 2/22/17 the facility Administrator provided the surveyor a copy of the Facility Reported Incidents (FRIs) that were faxed to the Virginia Department of Health Professions regarding Resident #3 being physically restrained documented in part, as follows:

1. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: Nurse restrained resident with a gait belt to a wheelchair.
Name of employee involved and their position: LPN #2

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Employee action initiated or taken: Nurse will have employment terminated.

2. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: LPN did not report seeing a gait belt being used as a restraint on a resident.
Name of employee involved and their position: LPN #4
Employee action initiated or taken: Formal counseling, re-educated on abuse policy.

3. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: CNA did not report seeing a gait belt being used as a restraint on a resident.
Name of employee involved and their position: CNA #3
Employee action initiated or taken: Formal counseling, re-educated on abuse policy.

4. Injuries: No
Incident Type: Allegation of abuse/mistreat
Describe incident, including location, and action taken: LPN did not report seeing a gait belt being used as a restraint on a resident.
Name of employee involved and their position: LPN #1
Employee action initiated or taken: Formal counseling, re-educated on abuse policy.

On 2/22/17 the Director of Nursing provided the surveyor a copy of her investigation and disciplinary actions regarding Resident #3 being physically restrained with a gait belt which is documented in part, as follows:

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Investigation done on reported use of a gait belt as a restraint on (Name of Resident #3).

Spoke to 44 employees from all shifts and departments: No one has ever seen any kind of a restraint on (Name of Resident #3) except the following:

Name LPN #4 stated she had seen (Name of Resident #3) with a gait belt once a month or two ago. I asked if she attempted to remove it or report it and she stated that it wasn't her hall and she didn't want to interfere.

Conclusion: (Name of LPN #4) had knowledge of a resident being restrained but did not witness the restraint being put on.

(Name of LPN #2): suspended, reported to the State Board of Nursing, termination.
(Name of CNA #1): Formal written counseling, work performance monitoring.
(Name of CNA #3): Formal written counseling, work performance monitoring.
(Name of LPN #4): Formal written counseling, work performance monitoring.

On 4/22/17 at 3:10 p.m. a phone interview was conducted with LPN #4 regarding her statement to the Director of Nursing that she had witnessed Resident #3 being physically restrained with a gait belt. LPN #4 was asked to explain what she had witnessed regarding Resident #3 being physically restrained. LPN #4 stated, "I saw (Name of Resident #3) restrained about a month ago. She was restrained with a gait belt in her wheelchair in the doorway of her room. I thought to myself wow! I got distracted on my own side and forgot about it because I was trying to take care of my

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residents too." The surveyor asked, "Did you try to remove the restraint or report it?" LPN #4 stated, "No, I did not." The surveyor asked, "At the time you saw her restrained did you think it was abuse?" LPN #4 stated, 'Well, yes and no, because she has fallen so many times." The surveyor asked, "Is physically restraining a resident abuse and are you a mandated reporter of abuse?" LPN #4 stated, "It is abuse no doubt about it and yes, I'm a mandated reporter."

Resident #3's Nurse's Note dated 2/21/17 at 14:15(2:15) p.m. by the Director of Nursing informing the resident's daughter of her mother being physically restrained by a gait belt is documented in part, as follows:

Call placed to (Name of Resident #3's daughter) to notify her that an employee applied a gait belt to prevent resident from rising up out of her w/c and falling. I explained that this was non-compliance of our operating procedures and policies and it was being investigated. Because of the non-compliance the Department of Health was also notified. (Name of Resident #3's daughter) did not have any further question. (Name of Resident #3's Attending Physician) was also notified.

Resident #3's Nurse's Note dated 2/22/17 at 15:48 (3:48) p.m. by the Administrator informing the resident's daughter of her mother being physically restrained by a gait belt is documented in part, as follows:

"Spoke with resident's daughter, Emergency Contact about the findings of the investigation completed by the facility in regards to the gait belt restraint. Informed daughter that the investigation

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found that the resident was abused. Reiterated that her mother had no physical injuries. Informed her that staff involved will no longer work at the facility. Informed her if she had concerns or questions to please contact me at the facility."

On 2/23/17 at 2:30 p.m. a phone interview was conducted with Resident #3's Attending Physician regarding the resident being physically restrained with a gait belt on 1/9/17. Resident #3's Attending Physician was asked if he was called and consulted with on the night the resident was physically restrained with a gait belt. The Attending Physician stated, "Yesterday was the first I heard of her being restrained. I didn't think we even restrained residents anymore. I would have expected them to call me if she was having a change in her condition, but I would not have given an order for a restraint."

The facility "Code of Conduct" updated 11/21/16 documented in part, as follows:

Legal Responsibilities:

Fraud and Abuse: Any employee who suspects a fraud and abuse issue is required to promptly report it to their supervisor. If the employee is not comfortable reporting the issue to their supervisor, the employee may report it to the Chief Compliance Officer.

Licensure and Certification: All employees must comply with licensure and certification laws applicable to the operation of the facility.

The facility policy titled "Virginia Resident Abuse Policy" last revised 2/21/17 is documented in part,

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as follows:

Policy:
This facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone.

Definitions:

Abuse- Includes actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, mental abuse including abuse facilitated or enabled through the use of technology, misappropriation of resident property, exploitation, involuntary seclusion and injuries of unknown source, physical and chemical restraints.

(*Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury.)

Restraints: (physical or chemical)-may only be used per MD order and in compliance with regulations and guidelines of Fall Prevention and Management Policy and Procedure.

Procedure:

3) Prevention and Identification

Facility's procedures will include:
f. The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs.

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The facility policy titled "Restraints" last revised 7/2015 is documented in part, as follows:

Policy:
Physical and/or chemical restraints will be initiated only after a comprehensive review determines that they are necessary to treat the resident's medical symptoms that warrant their use.

Definitions:
Physical Restraint-any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

Procedure: Physical Restraints

A) Using the Restraint Decision Tree (Form 3.40) determine if the device restricts the residents freedom of movement.
2. If the device restricts freedom of movement it is a restraint.

B) If the device restricts freedom of movement it is a restraint. Before proceeding with the device the interdisciplinary team:
1. Evaluates factors leading to the consideration of the device.
2. Determine that all the resident's needs are being met and the need to restrain is not due to unmet needs.
3. Determines that all alternative measures have been attempted and found to be unsuccessful.
4. Weighs the risks versus benefits of the

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restraint being considered.

5. Involve resident and family in decision making and educate those regarding risks and benefits.

6. Analyze all information and decide which is device most appropriate.

a. What has happened/or is happening to the resident.

b. When is the need occurring?

c. What is the cause?

d. What interventions have been tried?

e. Why didn't previous interventions work?

f. What is the least restrictive device?

g. Will it enhance resident's quality of life?

C) Physician order must be obtained that specifies type of restraint, reason for use, and the duration of the restraint.

D) Resident's responsible party will be educated on risk and benefits of device and sign the Informed Consent for Use of Restraints (Form 3.41).

The facility policy titled "Resident Rights and Facility Responsibilities" last revised 11/16 is documented in part, as follows:

Policy: It is the facility's policy to abide by all resident rights, and to communicate these rights to residents and their designated representatives in a language that they can understand.

3. Resident Right and Facility responsibilities are:

(a) Resident Rights: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and

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services inside and outside the facility, including those specified in this section.

(1) Dignity, Respect, and Quality of Life: a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

(e) Respect and Dignity:

(1) Restraints: The right to be free from any physical or chemical restraints imposed for purposes if disciplined or convenience, and not required to treat the resident's medical symptoms, consistent with 483.12(a)(2).

On 2/23/17 at 3:20 p.m. a pre-exit conference was conducted with the Administrator, the Director of Nursing, the Compliance Nurse, and the Regional Vice-President of Operations where the above information was shared. The surveyor asked the Administrator if a resident is chemically or physically restrained to prevent movement without injury or harm is this abuse. The Administrator stated, "At this time yes, going through the process of this and rewriting the abuse policy it is considered abuse." The Director of Nursing was asked if she would have expected her staff to come forward as mandated reporters when they saw Resident #3 restrained. The Director of Nursing stated, "Yes, absolutely. Restraining with a gait belt is a dignity issue with the reasonable person concept. It was inappropriate to have a gait belt on as a restraint." The surveyor asked the Director of Nursing what she would have expected for her staff to do instead of restraining the resident. The Director

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of Nursing stated, "I would have expected them to redirect her, gotten her up and walked her, to document her behavior, to notify the doctor, and if staff see someone restrained to take it off and report it." The Administrator was asked, "What is it meant to be treated with dignity and respect" The Administrator stated, "How You would want to be treated." The surveyor then asked, "How were the residents failed?" The Administrator stated, "By allowing all of this to happen." The Regional Vice-President of Operations stated, "We are not happy with the way the residents were treated at all. All we can do is move forward from here." Prior to exit no further information was shared.

(1) Psychosis: any major mental disorder of organic or emotional origin characterized by a gross impairment in reality testing, in which the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect references about external reality, even in the face of contrary evidence.

(2) Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses.

(3) Depression: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality.

The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

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F 225 SS=D	This is a COMPLAINT DEFICIENCY INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and	F 225		3/17/17

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F 225	Continued From page 81 misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to ensure all alleged violations involving abuse were reported immediately to the Administrator of the facility and other officials to include the State Survey Agency in accordance with State law, failed to thoroughly investigate and prevent further potential abuse while the investigation was	F 225	F-225 1 A Res. # 1 was physically examined to ensure no restraint was in place and no injury incurred. 1 B FRI was submitted to the DOH/OLC regarding res. # 1. All required agencies, MD, and RP were notified in compliance with regulatory requirements. 2. All residents are at risk for this issue.	

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F 225	Continued From page 82 in progress for 1 of 10 residents in the survey sample, Resident #1. Based on a complaint investigation, Resident #1 had been physically restrained with a gait belt to a wheelchair to prevent movement and not to treat medical symptoms. Multiple staff observed the abuse and failed to stop the abuse, protect the resident and as Mandated Reporters report immediately. The facility staff failed to protect other residents from abuse during the ongoing investigation of the physical restraint. The facility staff failed to thoroughly investigate an allegation of abuse, and failed to report to other officials to include the State Survey Agency of an allegation of abuse. The findings included: The State Survey Agency received an anonymous complaint on February 15, 2017 that alleged a resident had been left in a chair restrained all day and overnight. The resident identified in the complaint was Resident #1. 1. Resident #1 was originally admitted to the facility on 12/23/16 and readmitted on 1/4/17 following a short hospital stay from 12/28/16 through 1/4/17 for acute urinary retention (1). Diagnoses included BPH (benign prostatic hyperplasia-an enlarged prostate), and Alzheimer's dementia. The current MDS (Minimum Data Set) a 30 day with an assessment reference date (ARD) of 1/31/17 coded the resident as scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status), indicating the resident had severely impaired daily decision making skills.	F 225	3 A Review of the Abuse Prevention Policy & Procedure with the Administrator and DON by the Regional Vice President of Operations. 3 B All facility staff were in-serviced on the amended Abuse Prevention & Reporting Policy and Procedure. 3 C Any allegation of abuse will be reported and investigated per regulation and established policy. 3 D Facility implemented a physical audit/exam of residents 5 x per week to monitor that no physical restraints are in use. 4 A The above audit will be performed 5x weekly randomly on all shifts to ensure restraints are not in use. 4 B The Administrator or designee will audit all allegations of abuse to ensure : - Reporting was done to all agencies - Thorough investigation was completed 4 C All audit results will be shared in QAPI meetings. 5. 3/17/17	

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The resident had a Foley catheter for bladder drainage.

An initial tour of the facility was conducted from 2:30 am to 3:00 am, on 2/21/17. During the initial tour of the facility all residents were observed in their beds asleep, to include Resident #1.

A night shift nurse (Licensed Practical Nurse/ LPN #3) working on the East unit where Resident #1's room was located was interviewed at 3:00 am. She was asked if she was aware of any allegations of a resident having been restrained to a wheelchair. She stated, "Yes, (name of Resident #1)". She was asked about the circumstances for the use of the restraint. She stated, "He had fallen earlier in the shift (3-11 pm shift), when I arrived to work he had a gait belt on...it was buckled behind the wheelchair, he was behind the nurses station in the wheelchair, he stayed up at the nurses station, periodically would be asked if he wanted to go back to bed...he was alert with confusion...he sat quietly, did not try to fight the restraint". When asked why the restraint was not removed, she stated, "Out of sight out of mind". She stated she had asked the CNA (Certified Nurse Aide/CNA#3) assigned to the resident to remove the gait belt and place the resident to bed at approximately 5:00 am.

As a result of the facility's investigation LPN#3 stated she was suspended for three days (2/10/17-2/12/17), inserviced and given a copy of the abuse and restraint policy. LPN #3 was asked if she was the one who initiated the gait belt restraint and stated, "No", she repeated that it had been placed on the resident by the 3-11 shift. She did not know who placed the restraint on the resident. LPN #3 stated, " When asked as a

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Mandated Reporter what should you have done? Her response was "Report it to the DON (Director of Nursing)".
LPN #3 failed to stop abuse, and immediately report it.

The gait belt was buckled in the back of the wheelchair; therefore, the resident could not remove it at will, which restricted freedom of movement.

On 2/21/17 at 3:20 am, the Director of Nursing (DON) arrived at the facility. The DON was interviewed about the allegation of Resident #1 being restrained with a gait belt. While in the DON's office this surveyor was provided with a copy of the facility's investigation report dated 2/10/17. This report noted Resident #1 "was found with a gait belt restraining him to the chair". The DON was asked if a FRI (Facility Reportable Incident) had been sent to the State Survey Agency for this incident, she stated, "No". When asked why a FRI had not been sent her response was that she did not consider this incident as abuse, as there was "no harm". The investigation did not include witness statements, interviews with all staff on shift, interviews with other potential witnesses such as other residents. She stated the staff failed to follow the facility's restraint policy. The DON stated she was made aware of the restraint when the Rehab. Director wheeled the resident to her office between 10-10:30 am on 2/10/17. The resident had a gait belt around his waist that was buckled in the back of the wheelchair. The investigation noted the 11-7 nurse was suspended for three days. The other two licensed nurses (LPN#1 and #2) involved were not suspended during the investigation.

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The investigation report failed to include all staff working the 3-11 pm and 11 pm-7 am shift on the East unit on 2/9/17. Of the ten (10) staffed worked five (5) were interviewed.

The DON failed to recognize that a physical restraint used to prevent movement and not to treat a medical symptom was abuse.

The DON failed to thoroughly investigate an allegation of abuse, report the allegation of abuse to the State Survey Agency and other officials as required by State law, and failed to protect other residents from abuse during an investigation of abuse.

On 2/21/17 at 4:00 am., the Administrator was interviewed about the physical restraint use for Resident #1. He stated, "I asked (DON name) the DON to do the investigation, we disciplined parties involved, write-ups were done, re-education and inservices." He stated the facility was a restraint free facility, when asked to clarify he stated, "As in we don't use them, we don't use restraints". When asked if the gait belt used as a restraint was abuse, he stated, "Abuse, no, we considered it not following procedure for gait belt use". When asked why a FRI was not sent to the State Survey Agency, he responded, " Because there was no injury involved". When asked if the staff involved were reported to the Board of Health Professions he stated that he did not report them as it was a "procedural issue" (a failure to follow the restraint policy).

The Administrator failed to ensure a FRI of an allegation of abuse was reported to the State Survey Agency and other officials as required by

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State law to include appropriate licensing agencies and registries. The Administrator failed to recognize that a physical restraint used to prevent movement and not to treat a medical symptom was abuse.

On 2/21/17 at 9:15 am, the 3-11 CNA (CNA#1) assigned to care for Resident #1 on 2/9/17 was interviewed. She stated, "He (Resident #1) gets agitated easily...if the nurses talk to him in a certain tone he gets really agitated...he was fine when I got here, after dinner he was up and down and up and down from the wheelchair to the bed...he was having one of those nights...the nurse (LPN#1) didn't want him to fall, they bought him up out of his room...he didn't want to come out of his room...they put him in the hallway near the nurses station...he kept trying to go back to his room...at one point he got up... then he was behind the nurses station...they got tired of him... (LPN#3) got the gait belt". When asked if she witnessed LPN#3 apply the gait belt to Resident #1 she stated, "No, but she has done this before...with (name of Resident #3). When asked when she stated, "it was in the last couple of months". When asked why they had restrained Resident #1 she stated, "They don't want to do the extra paperwork...they told me to leave him there...I didn't know what to do". When asked if restraining a resident with a gait belt is a form of abuse, she stated, "Yes...you should stop it first, and then report it". When asked why she did not report the abuse she stated, "I was scared of (name of LPN #1).

CNA#1 failed to stop abuse and immediately report it.

On 2/21/17 at 2:15 pm, the 11-7 CNA (CNA #3)

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assigned to care for Resident #1 on 2/9/17 was interviewed by phone. She was asked who had placed the restraint on the resident and stated, "He was already in the restraint at the nurses station...3-11 put the restraint on him..." She stated the resident was taken to his room at approximately 3:00 am to empty the Foley drainage bag, the restraint was removed and the resident was placed back at the nurses station in the wheelchair. She stated when she finished rounds at approximately 4:00 am, she noticed the restraint had been reapplied. She did not know by whom. She stated, "We are always short staffed".

CNA#3 failed to stop abuse and immediately report it.

On 2/21/17 at approximately 2:20 pm, LPN #1 was interviewed in person. She stated the resident had a fall during the evening medication pass at approximately 8:00 pm. The resident was found at his bedside on his knees. The resident was placed back into the wheelchair and then placed at the nurses station. She stated, "(name of LPN #2) was at the nurses station...when I went to go give more meds she had put the restraint on him...I had a lot to do with the computer and the fall...I didn't realize it (the gait belt) was tied to the chair...it didn't hit me it was a restraint...When asked if the resident was provided care by CNA #1 after he was placed in the wheelchair and before the next shift came in she stated, "I didn't recall she did". She continued to state that LPN #2 reported to the oncoming nurse (LPN #1) "We have him up here with a belt on". When asked if a restraint with a gait belt was a form of abuse, she stated, "Yes, I have just learned that...". The nurse was asked who was responsible for the resident she stated,

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"I am...I should have corrected that action and reported it to the Supervisor or DON immediately". When asked if the Supervisor was aware of the resident being restrained with a gait belt she stated, " I think she probably did know." When asked who placed the gait belt restraint on Resident #1 she stated, "I assume it was her (LPN #2)".

LPN #1 failed to recognize a physical restraint to prevent movement for staff convenience, and not to treat a medical symptom as abuse, failed to stop abuse and failed to report it immediately.

Review of the Nursing Daily Sheets noted LPN #1 was not suspended during the investigation to protect others from harm and allowed to work on 2/12/17.

On 2/21/17 at 2:50 pm, LPN #2 was interviewed in person in the presence of Surveyor #2. Her immediate response to explain the circumstances for the use of a gait belt as a restraint for Resident #1 was, "(name of LPN #3) is a liar...the resident was extremely agitated, he had fallen and she bought him to the nurses station...he kept wrapping his Foley catheter around the foot petals...(LPN #3) stated, I wish I had a gait belt...I helped her (LPN #3) put the gait belt on him...in between we tried to care of the other residents...we are always short (staffed)...it got to be a game...just to keep him from falling and pulling out his catheter...I asked (LPN #3) do you want me to take that gait belt off him, she said "No, keep it on him". When asked if the use of the gait belt as a restraint to prevent movement and not to treat a symptom was abuse, she stated, " I don't believe it is...I don't know what else to do...you're under pressure to get your stuff

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done...we were understaffed...". When asked if the physician was called for a restraint order, she stated, "No". When asked if the chain of command (the Administrator, DON, Supervisor) were okay with the use of the gait belt as a restraint she stated, " Yes, because I know the chain of command has seen it...and they haven't said anything". When asked if it was common practice, she stated, "No, it is not".

LPN #2 failed to recognize the use of a physical restraint to prevent movement, for staff convenience and not to treat a medical symptom was abuse.

Review of the Nursing Daily Sheets noted LPN #2 was not suspended during the investigation to protect other residents from harm and allowed to work on 2/10, 2/11, and 2/12/17.

On 2/23/17 at 1:30 pm, the DON was asked who was the designated Abuse Coordinator for the facility. She repeated the question twice and could not answer. She was asked if she would prefer the Administrator be asked, and stated "Yes". The Administrator was not able to answer the same question. The Administrator stated, "I guess it's me". The Regional Vice President of Operations stated it is usually the role of the Administrator.

The facility's investigation of the physical restraint for Resident #1 failed to:
1. Identify the staff member(s) responsible for the initial reporting.
2. Protect residents from harm during the investigation by failure to suspend all parties involved, to include LPN #1 and LPN #2, who were allowed to work during the investigation.

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3. Report the alleged violation and substantiated incident to the State Survey Agency and all other agencies as required.
4. Prevention-deployment of staff on each shift in sufficient numbers to meet the needs of the residents.

The facility's abuse policy titled "Virginia Resident Abuse Policy" revised 1/2017 failed to recognize and define the use of chemical or physical restraints as abuse, it read in part, as follows:
Policy: This facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone.
Definitions:
Abuse- Includes actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, mental abuse including abuse facilitated or enabled through the use of technology, misappropriation of resident property, exploitation, involuntary seclusion and injuries of unknown source. (*Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury.)
Procedure:
3) Prevention and Identification-Facility's procedures will include:
f. The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs.
6). Initial Reports
a. Timing-All allegations of Abuse...must be reported immediately* to the Administrator, Director of Nursing (DON) and to the applicable

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F 225	Continued From page 91 State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH (Department of Health) immediately, but not later than 2 hours after the allegation is made. 7). Investigation Protocol. The person investigation the incident should generally take the following actions: i. Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who witnessed or heard the incident; came in close contact with the resident the day of the incident...and employees who worked closely with the accused employee(s)... iii. Obtain written statements from the resident, if possible, the accused, and each witness. 9). Final report will be submitted to applicable State agency, after the investigation is completed, but no later than five (5) working days from the alleged occurrence. 10). In the case of staff-to-resident Abuse...the facility will follow Facility's procedure for disciplining an employee, depending upon the circumstances and results of the investigation. i. The facility will report the results of the investigation to the appropriate licensing agencies and registries in accordance with the law. The above findings was shared during a pre-exit meeting with the Administrator, the Vice President of Operations and the Director of Nursing on 2/23/17.	F 225		
F 226 SS=L	COMPLAINT DEFICIENCY DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3)	F 226		3/17/17

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F 226	Continued From page 92 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to develop and implement written policies and procedures that prohibit and prevent abuse.	F 226	F-226 1 A The facility□s Abuse Policy was revised to include both physical and chemical restraints. 1 B All current facility staff were in-serviced on the revised Abuse Prevention Policy and the fact they are a	

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F 226	Continued From page 93 The facility's abuse policy and procedure revised January, 2017, failed to define the use of chemical or physical restraints as abuse. As a result, the facility staff failed to train employees on issues related to abuse, prevent abuse, identify abuse, thoroughly investigate abuse, protect residents from harm during an investigation, and report all alleged violations. Based on the complaint investigation Resident #1 in a sample of 10 residents, had been physically restrained with a gait belt to a wheelchair to prevent movement and not to treat medical symptoms. Multiple staff observed the abuse and failed to stop the abuse, protect the resident and as Mandated Reporters report immediately. The facility Administration team to include the Administrator, the Director of Nursing and the Rehab Manager, and Licensed Practical Nurses failed to recognize the use of a physical restraint as abuse. The facility staff failed to protect other residents from abuse during the ongoing investigation of the physical restraint. The facility staff failed to provide training to their staff that at minimum educated staff on activities that constituted abuse. During the course of the complaint investigation another resident was identified as having been physically restrained with a gait belt, Resident #3. Immediate Jeopardy was called on 2/21/17 at 10:00 am., under Abuse Prohibition Policies and Procedures-Freedom from Abuse, Neglect and Exploitation. The findings included: The State Survey Agency received an	F 226	mandated reporter of abuse. 2. All residents are at risk for this issue. 3 A Current staff in-serviced on the revised Abuse Policy and Mandated Reporter. 3 B New employees will be in-serviced on the new Abuse Policy including Mandated Reporting by the ADON or designee. 3 C Abuse Prevention info has been added to employee reference card which can be attached to their name badge. 4 A Random audits weekly by the Administrator or designee of current employees to ensure they understand abuse and their role as a mandated reporter x 60 days and then randomly x 30 days. 4 B All audit results will be shared in QAPI meetings. 5. 3/17/17	

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anonymous complaint on February 15, 2017, that alleged a resident had been left in a chair restrained all day and overnight. The resident identified in the complaint was Resident #1.

1. Resident #1 was originally admitted to the facility on 12/23/16 and readmitted on 1/4/17 following a short hospital stay from 12/28/16 through 1/4/17 for acute urinary retention (1). Diagnoses included BPH (benign prostatic hyperplasia-an enlarged prostate), and Alzheimer's dementia.

The current MDS (Minimum Data Set) a 30 day with an assessment reference date (ARD) of 1/31/17 coded the resident as scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status), indicating the resident had severely impaired daily decision making skills. The resident had a Foley catheter for bladder drainage.

An initial tour of the facility was conducted from 2:30 am to 3:00 am, on 2/21/17. During the initial tour of the facility all residents were observed in their beds asleep, to include Resident #1.

A night shift nurse (Licensed Practical Nurse/ LPN #3) working on the East unit where Resident #1's room was located was interviewed at 3:00 am. She was asked if she was aware of any allegations of a resident having been restrained to a wheelchair. She stated, "Yes, (name of Resident #1)". She was asked about the circumstances for the use of the restraint. She stated, "He had fallen earlier in the shift (3-11 pm shift), when I arrived to work he had a gait belt on...it was buckled behind the wheelchair, he was behind the nurses station in the wheelchair, he

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stayed up all night at the nurses station, periodically would be asked if he wanted to go back to bed...he was alert with confusion...he sat quietly, did not try to fight the restraint". When asked why the restraint was not removed, she stated, "Out of sight, out of mind". She stated she had asked the CNA (Certified Nurse Aide/CNA#3) assigned to the resident to remove the gait belt and place the resident to bed at approximately 5:00 am.

LPN #3 was asked if she was the one who initiated the gait belt restraint and stated, "No", she repeated that it had been placed on the resident by the 3-11 shift. She did not know who placed the restraint on the resident. When asked as a Mandated Reporter what should you have done? Her response was "Report it to the DON (Director of Nursing)". LPN#3 stated she was suspended for three days (2/10/17-2/12/17), inserviced and given a copy of the abuse and restraint policy.

LPN #3 failed to stop abuse, and immediately report it.

The gait belt was buckled in the back of the wheelchair; therefore, the resident could not remove it at will, which restricted freedom of movement.

On 2/21/17 at 3:20 am, the Director of Nursing (DON) arrived at the facility. The DON was interviewed about the allegation of Resident #1 being restrained with a gait belt. While in the DON's office this surveyor was provided with a copy of the facility's investigation report dated 2/10/17. This report noted Resident #1 "was found with a gait belt restraining him to the chair".

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The DON did not obtain written witness statements. The DON was asked if the Physician and the Resident Representative were notified by the facility that a gait belt was used to restrain Resident #1, she stated, "No". The DON was asked if a FRI (Facility Reportable Incident) had been sent to the State Survey Agency for this incident, she stated, "No". When asked why a FRI had not been sent her response was that she did not consider this incident as abuse, as there was "no harm". She stated the staff failed to follow the facility's restraint policy. The DON stated she was made aware of the restraint when the Rehab Director wheeled the resident to her office between 10-10:30 am on 2/10/17. The resident had a gait belt around his waist that was buckled in the back of the wheelchair. The investigation noted the 11-7 nurse was suspended for three days. The other two licensed nurses (LPN#1 and #2) involved were not suspended during the investigation.

The investigation report failed to include all staff working the 3-11 pm and 11 pm-7 am shift on the East unit on 2/9/17. Of the ten (10) staffed worked five (5) were interviewed.

The DON failed to recognize that a physical restraint used to prevent movement and not to treat a medical symptom was abuse.

The DON failed to thoroughly investigate an allegation of abuse, report the allegation of abuse to the State Survey Agency and other officials as required by State law, and failed to protect other residents from harm during an investigation of abuse.

On 2/21/17 at 4:00 am., the Administrator was

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interviewed about the physical restraint use for Resident #1. He stated, "I asked (DON name) the DON to do the investigation, we disciplined parties involved, write-ups were done, re-education and inservices." He stated the facility was a restraint free facility, when asked to clarify he stated, "As in we don't use them, we don't use restraints". When asked if the gait belt used as a restraint was abuse, he stated, "Abuse, no, we considered it not following procedure for gait belt use". When asked why a FRI was not sent to the State Survey Agency, he responded, " Because there was no injury involved". When asked if the staff involved were reported to the Board of Health Professions he stated that he did not report them as it was a "procedural issue" (a failure to follow the restraint policy).

The Administrator failed to recognize that a physical restraint used to prevent movement and not to treat a medical symptom was abuse.

The Administrator failed to ensure a FRI of an allegation of abuse was reported to the State Survey Agency and other officials as required by State law to include appropriate licensing agencies and registries.

On 2/21/17 at 9:15 am, the 3-11 CNA (CNA#1) assigned to care for Resident #1 on 2/9/17 was interviewed. She stated, "He (Resident #1) gets agitated easily...if the nurses talk to him in a certain tone he gets really agitated...he was fine when I got here, after dinner he was up and down and up and down from the wheelchair to the bed...he was having one of those nights...the nurse (LPN#1) didn't want him to fall, they bought him up out of his room...he didn't want to come out of his room...they put him in the hallway near

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the nurses station...he kept trying to go back to his room...at one point he got up... then he was behind the nurses station...they got tired of him... (LPN#3) got the gait belt". When asked if she witnessed LPN#3 apply the gait belt to Resident #1 she stated, "No, but she has done this before...with (name of Resident #3). When asked when she stated, "it was in the last couple of months". When asked why they had restrained Resident #1 she stated, "They don't want to do the extra paperwork...they told me to leave him there...I didn't know what to do". When asked if restraining a resident with a gait belt is a form of abuse, she stated, "Yes...you should stop it first, and then report it". When asked why she did not report the abuse she stated, "I was scared of (name of LPN #1).

CNA#1 failed to stop abuse and immediately report it.

On 2/21/17 at 2:15 pm, the 11-7 CNA (CNA #3) assigned to care for Resident #1 on 2/9/17 was interviewed by phone. She was asked who had placed the restraint on the resident and stated, "He was already in the restraint at the nurses station...3-11 put the restraint on him..." She stated the resident was taken to his room at approximately 3:00 am to empty the Foley drainage bag, the restraint was removed and the resident was placed back at the nurses station in the wheelchair. She stated when she finished rounds at approximately 4:00 am, she noticed the restraint had been reapplied. She did not know by whom. She stated, "We are always short staffed".

CNA#3 failed to stop abuse and immediately report it.

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On 2/21/17 at approximately 2:20 pm, LPN #1 was interviewed in person. She stated the resident had a fall during the evening medication pass at approximately 8:00 pm. The resident was found at his bedside on his knees. The resident was placed back into the wheelchair and then placed at the nurses station. She stated, "(name of LPN #2) was at the nurses station...when I went to go give more meds she had put the restraint on him...I had a lot to do with the computer and the fall...I didn't realize it (the gait belt) was tied to the chair...it didn't hit me it was a restraint...When asked if the resident was provided care by CNA #1 after he was placed in the wheelchair and before the next shift came in she stated, "I didn't recall she did". She continued to state that LPN #2 reported to the oncoming nurse (LPN #1) "We have him up here with a belt on". When asked if a restraint with a gait belt was a form of abuse, she stated, "Yes, I have just learned that...". The nurse was asked who was responsible for the resident she stated, "I am...I should have corrected that action and reported it to the Supervisor or DON immediately". When asked if the Supervisor was aware of the resident being restrained with a gait belt she stated, " I think she probably did know." When asked who placed the gait belt restraint on Resident #1 she stated, "I assume it was her (LPN #2)".

LPN #1 failed to recognize a physical restraint to prevent movement and not to treat a symptom was abuse, failed to stop abuse and failed to report it immediately.

Review of the Nursing Daily Sheets noted LPN #1 was not suspended during the investigation to protect others from harm and allowed to work on

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2/12/17.

On 2/21/17 at 2:50 pm, LPN #2 was interviewed in person in the presence of Surveyor #2. Her immediate response to explain the circumstances for the use of a gait belt as a restraint for Resident #1 was, "(name of LPN#3) is a liar...the resident was extremely agitated, he had fallen and she bought him to the nurses station...he kept wrapping his Foley catheter around the foot petals...(LPN #3) stated, I wish I had a gait belt...I helped her (LPN #3) put the gait belt on him...in between we tried to care of the other residents...we are always short (staffed)...it got to be a game...just to keep him from falling and pulling out his catheter...I asked (LPN #3) do you want me to take that gait belt off him, she said "No, keep it on him". When asked if the use of the gait belt as a restraint to prevent movement and not to treat a symptom was abuse, she stated, " I don't believe it is...I don't know what else to do...your under pressure to get your stuff done...we were understaffed...". When asked if the physician was called for a restraint order, she stated, "No". When asked if the chain of command (the Administrator, DON, Supervisor) were okay with the use of the gait belt as a restraint she stated, " Yes, because I know the chain of command has seen it...and they haven't said anything". When asked if it was common practice, she stated, "No, it is not".

LPN #2 failed to recognize the use of a physical restraint to prevent movement, for staff convenience and not to treat a medical symptom was abuse.

Review of the Nursing Daily Sheets noted LPN #2 was not suspended during the investigation to

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protect other residents from harm and allowed to work on 2/10/, 2/11, and 2/12/17.

The facility's Abuse policy was reviewed. The policy was revised January, 2017. The revised Abuse Policy failed to define the use of chemical and physical restraint(s) without a physician order and not to treat a symptom was abuse.

The facility's abuse training for employees was reviewed. LPN #1 did not receive on-going sessions/ in-services on issues related to abuse prohibition practices, Resident Rights or Restraint Training.

During the complaint investigation multiple staff stated understaffing was a concern.

The Nursing Daily Sheets for 2/9/17 evidenced the following staffing:
East Unit: 3 pm-11 pm= 2 nurses, 3 CNAs plus on orientee
East Unit: 11 pm-7 am=1 nurse, 3 CNAs
West Unit: 3 pm-11 pm=2 nurses, 4 CNAs
West Unit: 11 pm-7 am=1 nurse, 2 CNAs

During the initial tour of the facility on 2/21/17 at 2:30 am, the census in the building was 105 residents, staffing consisted of:
East Unit: 11 pm-7 am=1 nurse, 1 CNA
West Unit: 11 pm-7 am=1 nurse, 2 CNAs

The facility's investigation of the physical restraint for Resident #1 failed to:
1. Identify the staff member(s) responsible for the initial reporting.
2. Protect residents from harm during the investigation by failure to suspend all parties involved, to include LPN #1 and LPN #2, who

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were allowed to work during the investigation.
3. Report the alleged violation and substantiated incident to the State Survey Agency and all other agencies as required.
4. Prevention-deployment of staff on each shift in sufficient numbers to meet the needs of the residents.

2. During the course of the complaint investigation it was found that another resident had been affected by the same deficient practice of using a gait belt restraint for preventing movement, staff convenience and not to treat a medical symptom, Resident #3.

Resident #3 was a 84 year old admitted to the facility on 11/23/14 with diagnoses to include Psychosis (1), Dementia (2), Major Depressive Disorder (3). Resident #3 resided on the West unit.

The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 1/16/17. The Brief Interview for Mental Status (BIMS) was a 3 out of a possible 15 which indicated Resident #3 was severely cognitively impaired and incapable of daily decision making.

On 2/21/17 at 9:15 am, the 3-11 CNA (CNA#1) was interviewed. During the interview she was asked if she had witnessed any other resident's restrained. CNA #1 stated, " Yes, in the past couple of months (Name of Resident #3) with a gait belt. When I have a break I walk around the halls. She (Resident #3) was sitting in the hallway in a wheelchair by the nurse's station with

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a gait belt around her, she is another one that is up and down and becomes combative easily." The surveyor asked, "Who was the nurse taking care of the resident that night?" CNA #1 stated, "(Name of LPN #2) (Licensed Practical Nurse).

CNA #1 failed to stop abuse and report it.

On 2/21/17 at 2:50 p.m. an interview was conducted with LPN #2. During the interview LPN #2 was asked if she had witnessed any other residents being restrained. LPN #2 stated, "Yes, (Name of Resident #3) about a month ago with a gait belt in her wheelchair. She is restrained quite often, she gets real combative and combative with others." The Surveyor asked, "What else could have been for the resident instead of restraining her?" LPN #2 stated, "They could have looked at the care plan for interventions like a lap-buddy, alarms, walking her, or toileting her." The surveyor then asked, "Have you ever restrained (Name of Resident #3)?" LPN #2 stated, "Yes, I have restrained her about a month ago with a gait belt." The surveyor asked, "Do you remember what day you actually restrained the resident?" LPN #2 stated, "It was in January like the 9th or 24th. I think it was January the 9th because there was not enough staff to keep my other patients safe." The surveyor asked LPN #2 if Resident #3's physician had been notified by her on January 9th that Resident #3 had been restrained and if an order for the restraint had been obtained from the physician. LPN #2 stated, "No, I did not call the doctor or get an order. I can't remember what she was doing all I remember is that we were short staffed." The surveyor asked LPN #2 if it was abuse to physically restrain a resident. LPN #2 stated, "I don't believe it is. I didn't know what

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else to do, you are under pressure to get your stuff done and understaffed."

LPN#2 restrained Resident #3 for staff convenience due to staffing.

The Nursing Daily Sheets for 1/9/17 evidenced the following staffing for a census of 97:
East Unit: 3 pm-11 pm= 2 nurses, 4 CNAs
East Unit: 11 pm-7 am=1 nurse, 3 CNAs
West Unit: 3 pm-11 pm=2 nurses, 4 CNAs
West Unit: 11 pm-7 am=1 nurse, 2 CNAs

On 2/23/17 at 1:30 p.m. the DON was asked who was the designated Abuse Coordinator for the facility. She was not able to answer. The Administrator was asked the same question. The Administrator was not able to definitively answer. The Regional Vice President of Operations answered and stated it is usually the role of the Administrator.

The facility's abuse policy titled "Virginia Resident Abuse Policy" revised 1/2017 failed to recognize and define the use of chemical or physical restraints as abuse, it read in part, as follows:
Policy: This facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy.
3) Prevention and Identification-Facility's procedures will include:
f. The deployment of staff on each shift in

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sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs.
6). Initial Reports
a. Timing-All allegations of Abuse...must be reported immediately* to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH (Department of Health) immediately, but not later than 2 hours after the allegation is made.
7). Investigation Protocol. The person investigation the incident should generally take the following actions:
i. Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who witnessed or heard the incident; came in close contact with the resident the day of the incident...and employees who worked closely with the accused employee(s)...
iii. Obtain written statements from the resident, if possible, the accused, and each witness.
9). Final report will be submitted to applicable State agency, after the investigation is completed, but no later than five (5) working days from the alleged occurrence.
10). In the case of staff-to-resident Abuse...the facility will follow Facility's procedure for disciplining an employee, depending upon the circumstances and results of the investigation.
i. The facility will report the results of the investigation to the appropriate licensing agencies and registries in accordance with the law.
Definitions:
Abuse- Includes actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal

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abuse, sexual abuse, physical abuse, mental abuse including abuse facilitated or enabled through the use of technology, misappropriation of resident property, exploitation, involuntary seclusion and injuries of unknown source. (*Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury.)
11). Reporting:
*Notify next of kin
* Notify resident's physician when the facility receives a complaint of alleged abuse...
Procedure:

The plan for removal of Immediate Jeopardy was accepted on 2/21/17 at 3:45 pm. The plan included the following steps:
1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
1a. Both residents (#1 and #3) were assessed by an Registered Nurse for injury.
1b. Observe to ensure no physical restraint in place.
1c. FRI will be completed and submitted to the DOH (Department of Health)/OLC (Office of Licensure and Certification/State Survey Agency).
2. How will the facility identify other residents having the potential to be affected by the same deficient practice.
2 a. All residents have the potential to be affected.
3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.
3a. Every current resident will be physically examined to ensure that no form of physical restraint is in place.

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F 226	Continued From page 107 3b. Will revise existing Abuse Prevention Policy & Procedure to include restraints as abuse if not in compliance with all regulatory requirements. 3c. All current staff employees will be educated/inserviced on Abuse Prevention P&P, use of restraints, reporting of events to Supervisor/DON/Administrator, or compliance hotline. 3d. Administrator and DON will be educated/inserviced to report any allegation/suspected abuse to DOH/OLC and other agencies as required per regulation. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. 4a. Audit will be completed 5x week, to inspect all current residents and ensure no physical restraints in place. Audits will be conducted randomly on all 3 shifts. Audit will be completed by DON or management designee. Audit will consist of visual inspections of each resident to ensure no restraint in place. 4b. Any occurrence of alleged/suspected abuse will be reported by the Administrator /DON to DOH/OLC and other required agencies. 5. Staff education/inservice will be provided on all 3 shifts 2/21/17 and 2/22/17. Part time, PRN (as needed) or staff who have not been scheduled to work by 2/23/17 will be contacted by phone and education provided. The facility revised it's existing Abuse Prevention Policy & Procedure to include restraints as abuse. The revision included: Restraints (physical or chemical)- may only be used per MD order and in compliance with regulations and guidelines of Fall Prevention and Management P&P. After accepting the plan for removal of Immediate	F 226		

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F 226	Continued From page 108 Jeopardy from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level two pattern.	F 226		
F 353 SS=E	COMPLAINT DEFICIENCY SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4) 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not	F 353		3/17/17

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F 353	Continued From page 109 limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, record reviews, and staff interviews, the facility staff failed to have sufficient nursing staff including nurse aides to provide care and respond to resident needs. The findings included: The facility staff failed to have sufficient staff including nurse aides to provide care and respond to residents needs. Two residents (Resident #1 and Resident #3) were found with gait belts restraining them to wheelchairs. For resident specific information cross reference to F-Tag- 223. A review of the facility's Job Description for the Administrator indicated: "Delegation of Authority- As the Administrator, you are delegated the administrative authority, responsibility and	F 353	F-353 1. On 2/23/17 the Administrator received authority to utilize Nurse Staffing Agency if needed to provide adequate daily staffing. 2. All residents are at risk for this issue. 3 A DON/ADON will create a master schedule for nursing department to facilitate sufficient staffing. 3 B DON will determine number of vacant positions and then advertise, recruit, hire for those positions. 3 C DON or designee will review work schedule daily for adequate staffing numbers and will attempt to cover any vacancies (example: call off for sickness) with available staff or agency. 3 D DON has designated a on call nurse who is to be called if additional staffing is needed.	

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F 353	Continued From page 110 accountability necessary for carrying out your assigned duties. You are responsible for carrying out the operational core responsibilities established by the company and facility. You are responsible for the oversight of the resident care policies established by the facility. Position Qualifications- Core Competencies/Skill Sets- Will need to have knowledge of and manage facility budgets, including revenue and expenses. Understanding of Hours of Labor and how to calculate PPD'S (PER PATIENT DAY)." A review of the Director of Nursing (DON) Job Description indicated: "As the Director of Nursing it your responsibility to organize, develop and direct the overall operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility. Essential Function, Duties and Responsibilities- Responsible for the daily calculation of the direct nursing care personal on duty each shift. Assure there is a daily work assignment process in place. Maintain a master schedule to enhance staffing and enable an accurate need for staffing at all times." The following as work daily schedule/census and the budgeted schedule/census: Date: 1/7/17-census 99 Registered Nurse (RN) Licence Practical Nurse (LPNs) - Certified Nurse Assistance (CNA)	F 353	4 A DON or designee will report nursing staffing to Administrator daily. 4 B QAPI Committee will receive reports from the DON if staffing issues are encountered. An action plan will be developed as needed. 5. 3/17/17	

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7-3 3-11 11-7
RN (1) RN (1) RN (0)
LPN (4) LPN (4) LPN (3)
CNA (7) CNA (6) CNA (3)

Date: 1/8/17 - census 97

RN (1) RN (1) RN (0)
LPN (4) LPN (3) LPN (2)
CNA (7) CNA (6) CNA (3)

Date:1/9/17 - census 97

RN (0) RN (1) RN (0)
LPN (4) LPN (3) LPN (2)
CNA (9) CNA (10) CNA (5) one staff in training

Date: 1/10/17 - census 98

RN (0) RN (1) RN (0)
LPN (4) LPN (4) LPN (3)
CNA (10) CNA (10) CNA (4)

Date: 1/11/17 - census 99

RN (1) RN (.5) RN (0)
LPN (4) LPN (4) LPN (3)
CNA (11) CNA (12) CNA (5)

Date: 2/6/17 - census (not available)

RN (1) RN (1) RN (0)
LPN (3) LPN (3) LPN (2)
CNA (10) CNA (9) CNA (3)

Date: 2/7/17 census (not available)

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RN (1) RN (1) RN (0)
LPN (4) LPN (4) LPN (2)
CNA (11) CNA (11) CNA (4)

Date: 2/8/17 census (not available)

RN (1) RN (1) RN (0)
LPN (4) LPN (4) LPN (2)
CNA (11) CNA (11) CNA (4)

Date: 2/9/17 census (not available)

RN (1) RN (1) RN (0)
LPN (4) LPN (4) LPN (2)
CNA (9) CNA (8) CNA (4)

Date: 2/10/17 census 102

RN (1) RN (1) RN (0)
LPN (4) LPN (4) LPN (2)
CNA (9) CNA (9) CNA (4)

Date: 2/16/17 census 104

RN (1) RN (1) RN (0)
LPN (4) LPN (4) LPN (2)
CNA (9) CNA (9) CNA (3)

Date: 2/17/17 census 105

RN (1) RN (0) RN (0)
LPN (4) LPN (4) LPN (2)
CNA (10) CNA (11) CNA (3)

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Date 2/18/17 census 105

RN (1)	RN (0)	RN (0)
LPN (4)	LPN (4)	LPN (2)
CNA (7)	CNA (10)	CNA (2)

Date 2/19/17 census 105

RN (1)	RN (1)	RN (0)
LPN (4)	LPN (4)	LPN (2)
CNA (7)	CNA (8)	CNA (3)

Date 2/20/17 census 105

RN (1)	RN (0)	RN (0)
LPN (4)	LPN (4)	LPN (2)
CNA (10)	CNA (11)	CNA (3)

A Budget analyses presented by the Administrator based on a census of 105 indicated: "Hands on Nursing

RN .18 = 18.9 hours /8 = 2.36 people
I would make this a 3-11 Superior Every day
A day shift house supervisor on Sat & Sun, and a 11-7 Supervisor Mon-Friday.

LPN .91 = 95.55 hours /8 = 11.94 staff
These are charge/med nurses
I would suggest by shift
5-5-2
or 4-5-3
or 5-4-3

CNA 2.10 = 220.5 hours /7.5 = 29.4 staff
I would suggest by shift
12-11-6

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A Nursing Assistant -Job Description Indicated: "Position Summary - The primary purpose of your job position is provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors.

Functions, Duties and Responsibilities: report all changes in the resident's condition to the Nurse Supervisor/Charge Nurse as soon as practical. Report all accidents and incidents you observe on the shift that they occur. Assist residents with activities of daily living such as daily hair care, shaving, dental and mouth care, bathing dressing/undressing, and nail care.

Assist with lifting, turning, moving, positioning and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc. Assist resident with bowel and bladder functions (i.e. take to bathroom, offer bed pan/urinal, portable commode, etc.) and provide incontinence care. Report all allegations of resident abuse and/or misappropriation of resident property."

A Nursing (Charge Nurse RN/LPN) Job Description indicated: The primary purpose of your job position is to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of nursing Services or Nurse supervisor

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to ensure that the highest degree of quality care is maintained at all times.

As Charge Nurse you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Complete accident/incident reports as necessary. Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care. Prepare and administer medications as ordered by the physician. Report and investigate all allegations of resident abuse and/or misappropriation of resident property."

On 2/23/17 CNA #2 was interviewed. This CNA stated when staffing on the 11-7 shift is down to three (3) and two (2) aides it is impossible to do all of the assigned work. We can not change and reposition residents every two hours. By the time you change and reposition each resident you are at the end of the hall and have to start all over again. Your shift by this time is over. We are also answering call lights.

An Investigation Report dated February 10, 2017, indicated: LPN #2 stated during the investigation, "Yes, I helped the nurse locate a gait belt after the resident had a fall at 8 PM. She did not think there was anything wrong with keeping the resident from falling. She stated that there was only four (4) aides."

An Investigative report dated February 10, 2017 indicated: LPN #1 stated during the investigation, "LPN #2 put the gait belt on him and that since she hadn't been a nurse as long as LPN #2 she didn't think anything about it. She wanted to keep

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F 353	Continued From page 116 him from falling again "since there was so much paperwork with a fall." On 2/23/17 at 3:20 P.M. during an interview with the Administrator, Director of Nurses, Regional Vice President of Operations (RVPO) and Corporate Nurse, when asked the question of how staff on the 11-7 shift work load assignments were tasked out for a census of 105 for four CNAs, the DON stated each CNA would have an assignment of (25) residents and one CNA would have twenty six. The LPNs would be expected to help out." When asked how the work assignment for a census of 105 and 3 CNAs be tasked out, the DON, stated each CNA would have an assignment of (35) residents." During this interview the DON was asked what tasks were the CNAs expected to carry out and the DON stated, "make rounds, ensure each resident was dry, change residents as needed and provide peri care, pass water, take residents to bathroom if needed." The LPNs were expected to pass medications, review orders of the day, ensure lab work orders were completed, assist CNAs. The Administrator was asked if staff (11-7) shift had complained about being short staffed, and he replied, "Yes". When asked for a Staffing Policy, the Administrator and the RVPO stated there was no "Staffing Policy". The facility staff failed to provide nursing staff including nurse aides to provide care and respond to resident needs.	F 353		
F 356 SS=C	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4)	F 356		3/17/17

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F 356	Continued From page 117 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data.	F 356		

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F 356	Continued From page 118 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to post Nurse Staffing Information on a daily basis and failed to maintain the posted daily nurse staffing data for a minimum of 18 months. The findings included: During the extended survey the posting of the Nurse Staffing data was not found. On 2/21/17 at 11:20 am, the Administrator was asked while at the West nursing station where was the posting of the Nurse Staffing was located. The Administrator shook his head and stated, "We don't have it posted." On 2/23/17 at 4:30 pm, a meeting was conducted with the Administrator, the DON, the Regional Vice President and the Corporate nurse in attendance. The above findings was shared. They indicated that a staff would now be delegated to post the Nurse Staffing Information on a daily basis. The DON would be responsible for generating the document. The DON was asked if the facility had maintained 18 months of Nurse Staffing Information, she stated "No".	F 356	F-356 1. Nursing staffing is now posted daily. 2. All residents are at risk for this issue. 3 A ADON or designee will fill out the daily nursing staffing and post it at both nursing units to include: - # of RNs, LPNs & CNAs for each shift - # of hours for RNs, LPNs & CNAs for each shift 3 B The ADON will maintain staffing sheets for the required 18 months. 4 A DON or designee will audit daily that the nursing staffing is posted x 60 days and then randomly x 30 days. 4 B Audit results will be shared in QAPI meetings. 5. 3/17/17	
F 490	EFFECTIVE ADMINISTRATION/RESIDENT	F 490		3/17/17

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F 490 SS=E	Continued From page 119 WELL-BEING CFR(s): 483.70 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, staff interviews, the facility staff failed to utilize it resources effectively and efficiently for personal as well as their education and/ or training. The findings included: The facility staff failed to administer its resources effectively and efficiently to provide nursing staff including nurse aides to ensure residents were able to maintain their highest physical, mental and psychosocial well -being. The facility staff failed to have sufficient staff including nurse aides to provide care and respond to residents' needs. Two residents (Resident #1 and Resident #3) were found with gait belts restraining them to wheelchairs. For resident specific information cross reference to F-Tag- 223. A review of the facility's Job Description for the Administrator indicated: "Delegation of Authority- As the Administrator, you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties. You are responsible for carrying out the operational core responsibilities	F 490	F-490 1 A On 2/23/17 the Administrator received authority to utilize Nurse Staffing Agency if needed to provide adequate daily staffing. 1 B The six CNAs cited have obtained the hours needed to meet the 12 hour requirement annually on 2/23/17. 2. All residents are at risk for this issue. 3 A DON/ADON will create a master schedule for nursing department to facilitate sufficient staffing. 3 B DON will determine number of vacant positions and then advertise, recruit, hire for those positions. 3 C DON or designee will review work schedule daily for adequate staffing numbers and will attempt to cover any vacancies (example: call off for sickness) with available staff or agency. 3 D DON has designated a on call nurse who is to be called if additional staffing is needed. 3 E ADON will audit current CNAs for education hours to ensure that they have the required 12 hours by their anniversary date. CNAs identified as needing additional	

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F 490	Continued From page 120 established by the company and facility. You are responsible for the oversight of the resident care policies established by the facility. Position Qualifications- Core Competencies/Skill Sets- Will need to have knowledge of and manger facility budgets, including revenue and expenses. Understanding of Hours of Labor and how to calculate PPD'S (PER PATIENT DAY)." A review of the Director of Nursing (DON) indicated: "As the Director of Nursing it your responsibility to organize, develop and direct the overall operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility. Essential Function, Duties and Responsibilities- Responsible for the daily calculation of the direct nursing care personal on duty each shift. Assure there is a daily work assignment process in place. Maintain a master schedule to enhance staffing and enable an accurate need for staffing at all times." The following as work daily schedule/census and the budgeted schedule/census: Date: 1/7/17-census 99 Registered Nurse (RN) Licence Practical Nurse (LPNs) - Certified Nurse Assistance (CNA) 7-3 3-11 11-7 RN (1) RN (1) RN (0)	F 490	training hours prior to their anniversary will be scheduled for appropriate training. 3 F Each month the ADON or designee will audit training records of CNAs with approaching anniversary date. If additional training is required, it will be scheduled. 4 A DON or designee will report nursing staffing to Administrator daily. 4 B QAPI Committee will receive reports from the DON if staffing issues are encountered. An action plan will be developed as needed. 4 C ADON will audit CNA training records quarterly to ensure they receive the required 12 hours of education annually. All audit results will be shared in QAPI meeting. 5. 3/17/17	

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F 490	Continued From page 121	F 490		

LPN (4) LPN (4) LPN (3)
CNA (7) CNA (6) CNA (3)

Date: 1/8/17 - census 97

RN (1) RN (1) RN (0)
LPN (4) LPN (3) LPN (2)
CNA (7) CNA (6) CNA (3)

Date:1/9/17 - census 97

RN (0) RN (1) RN (0)
LPN (4) LPN (3) LPN (2)
CNA (9) CNA (10) CNA (5) one staff in training

Date: 1/10/17 - census 98

RN (0) RN (1) RN (0)
LPN (4) LPN (4) LPN (3)
CNA (10) CNA (10) CNA (4)

Date: 1/11/17 - census 99

RN (1) RN (.5) RN (0)
LPN (4) LPN (4) LPN (3)
CNA (11) CNA (12) CNA (5)

Date: 2/6/17 - census (not available)

RN (1) RN (1) RN (0)
LPN (3) LPN (3) LPN (2)
CNA (10) CNA (9) CNA (3)

Date: 2/7/17 census (not available)

RN (1) RN (1) RN (0)
LPN (4) LPN (4) LPN (2)

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F 490	Continued From page 122 CNA (11) CNA (11) CNA (4) Date: 2/8/17 census (not available) RN (1) RN (1) RN (0) LPN (4) LPN (4) LPN (2) CNA (11) CNA (11) CNA (4) Date: 2/9/17 census (not available) RN (1) RN (1) RN (0) LPN (4) LPN (4) LPN (2) CNA (9) CNA (8) CNA (4) Date: 2/10/17 census 102 RN (1) RN (1) RN (0) LPN (4) LPN (4) LPN (2) CNA (9) CNA (9) CNA (4) Date: 2/16/17 census 104 RN (1) RN (1) RN (0) LPN (4) LPN (4) LPN (2) CNA (9) CNA (9) CNA (3) Date: 2/17/17 census 105 RN (1) RN (0) RN (0) LPN (4) LPN (4) LPN (2) CNA (10) CNA (11) CNA (3) Date 2/18/17 census 105 RN (1) RN (0) RN (0) LPN (4) LPN (4) LPN (2) CNA (7) CNA (10) CNA (2)	F 490		

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Date 2/19/17 census 105

RN (1)	RN (1)	RN (0)
LPN (4)	LPN (4)	LPN (2)
CNA (7)	CNA (8)	CNA (3)

Date 2/20/17 census 105

RN (1)	RN (0)	RN (0)
LPN (4)	LPN (4)	LPN (2)
CNA (10)	CNA (11)	CNA (3)

A Budget analyses presented by the Administrator based on a census of 105 indicated: "Hands on Nursing

RN .18 = 18.9 hours /8 = 2.36 people
I would make this a 3-11 Superior Every day
A day shift house supervisor on Sat & Sun, and a 11-7 Supervisor Mon-Friday.

LPN .91 = 95.55 hours /8 = 11.94 staff
These are charge/med nurses
I would suggest by shift
5-5-2
or 4-5-3
or 5-4-3

CNA 2.10 = 220.5 hours /7.5 = 29.4 staff
I would suggest by shift
12-11-6
or 11-11-7

A Nursing Assistant -Job Description Indicated: "Position Summary - The primary purpose of your job position is provide each of your assigned

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residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors.

Functions, Duties and Responsibilities: report all changes in the resident's condition to the Nurse Supervisor/Charge Nurse as soon as practical. Report all accidents and incidents you observe on the shift that they occur. Assist residents with activities of daily living such as daily hair care, shaving, dental and mouth care, bathing dressing/undressing, and nail care.

Assist with lifting, turning, moving, positioning and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc. Assist resident with bowel and bladder functions (i.e. take to bathroom, offer bed pan/urinal, portable commode, etc.) and provide incontinence care. Report all allegations of resident abuse and/or misappropriation of resident property."

A Nursing (Charge Nurse RN/LPN) Job Description indicated: The primary purpose of your job position is to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of nursing Services or Nurse supervisor to ensure that the highest degree of quality care is maintained at all times.

As Charge Nurse you are delegated the administrative authority, responsibility, and

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F 490	Continued From page 125	F 490		

accountability necessary for carrying out your assigned duties. Complete accident/incident reports as necessary. Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care. Prepare and administer medications as ordered by the physician. Report and investigate all allegations of resident abuse and/or misappropriation of resident property."

On 2/23/17 CNA #2 was interviewed. This CNA stated when staffing on the 11-7 shift is down to three (3) and two (2) aides it is impossible to do all of the assigned work. We can not change and reposition residents every two hours. By the time you change and reposition each resident you are at the end of the hall and have to start all over again. Your shift by this time is over. We are also answering call lights.

An Investigation Report dated February 10, 2017 indicated: LPN #2 stated during the investigation, "Yes, I helped the nurse locate a gait belt after the resident had a fall at 8 PM. She did not think there was anything wrong with keeping the resident from falling. She stated that there was only four (4) aides."

An Investigative report dated February 10, 2017 indicated: LPN #1 stated during the investigation, "LPN #2 put the gait belt on him and that since she hadn't been a nurse as long as LPN #2 she didn't think anything about it. She wanted to keep him from falling again since there was so much paperwork with a fall."

On 2/23/17 at 3:20 P.M. during an interview with the Administrator, Director of Nurses (DON),

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F 490	Continued From page 126 Regional Vice President of Operations (RVPO) and Corporate Nurse, when asked the question of how staff on the 11-7 shift work loads assignments were tasked out for a census of 105 for four CNAs, the DON stated, "each CNA would have have an assignment of (25) residents and one CNA would have twenty six. The LPNs would be expected to help out." When asked how the work assignment for a census of 105 and 3 CNAs be tasked out, the DON, stated each CNA would have an assignment of (35) residents During this interview the DON was asked what task were the CNAs expected to carry out? The DON stated, "make rounds, ensure each resident was dry, change residents as needed and provide peri care, past water, take residents to bathroom if needed." The LPNs were expected to pass medications, review orders of the day, ensure lab work orders were completed, assist CNAs. The Administrator was asked if staff (11-7) shift had complained about being short staffed, and he replied, "Yes". When asked for a Staffing Policy, the Administrator and the RVPO stated there was no "Staffing Policy". The facility staff failed to administer its resources effectively and efficiently to provide nursing staff including nurse aides to ensure residents were able maintain their highest physical, mental and psychosocial well -being.	F 490		
F 492 SS=E	COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD CFR(s): 483.70(b)(c)	F 492		3/17/17

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F 492	Continued From page 127 (b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. (c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, and staff interviews, the facility staff failed to comply with Federal, State and Local laws for reporting abuse as Mandated reporters. The findings included: The facility's Administrative staff failed to report	F 492	F-492 1 A FRI was submitted to DOH/OLC and all other required agencies regarding res. # 1 & 3. 1 B 100% of all current employees were in-serviced regarding the revised Abuse Prevention and Mandated Reporter. 2. All residents are at risk for this issue.	

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F 492	Continued From page 128 an incident of abuse involving two residents as Mandated Reporters. Two residents (Resident #1 and Resident #3) were found with gait belts restraining them to wheelchairs. For resident specific information cross reference to F-Tag- 223. A review of the facility's Job Description for the Administrator indicated: "Delegation of Authority- As the Administrator, you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties. You are responsible for carrying out the operational core responsibilities established by the company and facility. You are responsible for the oversight of the resident care policies established by the facility. In the area of Essential Function, Duties, and Responsibilities the Administrator is responsible for monitoring each department's activities, ensuring that each department attains and maintains compliance with State and federal requirements. Compliance Responsibilities- Maintain a reference library of written material, laws, etc. necessary for complying with current standards and regulations, and that will provide assistance in maintaining quality. Core Competencies/Skill Sets- Must have knowledge of State Rules and regulations for the state in which you operate. Must have knowledge of federal requirements for Long Term Care facilities, including Life Safety Code. A review of the Director of Nursing (DON) indicated: "As the Director of Nursing it your	F 492	3 A All new hires will be educated on Abuse Prevention and Reporting Policy and Procedure. Current employees will be in-serviced annually. 3 B Administrator or DON will implement FRI process and investigation for all allegations of abuse. Abuse Prevention and Reporting Policy & Procedure will be followed. 4 A All incidents of alleged abuse will be audited by the Administrator and DON to assure they were reported to the DOH/OLC and other agencies. 4 B Audit results will be shared in QAPI meetings. 5. 3/17/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 02/23/2017

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F 492	Continued From page 129	F 492		

responsibility to organize, develop and direct the overall operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility.

In the area of Essential function, duties, Responsibilities the DON is responsible for the reporting of any known or suspected allegations of abuse and/or misappropriation of resident property in accordance to the state guidelines.

A Review of the Virginia Department Social Services Mandated reporter notification form for the Administrator and the DON was not signed until February 22, 2017.

The State Code for mandated reporting include: Code 63.2-1603 through 1610. This means that the employees have been notified of their mandated report status. They are required to report or cause a report to be made to state Adult Protective Services (APS) either by calling the (1-800) Hot Line or appropriate local department of social services whenever they have reasonable cause to suspect that an adult age 60 or over or an incapacitated adult aged 18 and over and who is known to me in my professional or official capacity may be abused, neglected, or exploited."

During the survey the Administrator was asked several times what guidelines (Standards of Operation Manual- SOM) they were operating. The Administrator/DON repeatedly stated they were not aware that a restraint without medical symptoms and without a a physicians order and assessment was considered abuse.

During an interview with the Regional Vice

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F 492	Continued From page 130 President of Operations she was asked which set of regulations were the Administrator as well as her self operating under and she stated, "I just got a down load of regulations on February 9, 2017." She informed the surveyor that the down load were corrections which she was aware of. When asked to see the (SOM) in-which the Administrator was operating, no copy was presented. A revised Policy dated; February 21, 2017 Indicated: "Policy: It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents. misappropriation of resident property and injuries of unknown source. Definitions: Abuse- includes actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, mental abuse including abuse facilitated or enabled through the use of technology, misappropriation of resident property, exploitation, involuntary seclusion and injuries of unknown source, physical and chemical restraints. Restraints-(physical or chemical) - may only be used per MD order and in compliance with regulations and guidelines of Fall prevention and Management P & P (policy and procedure). The facility staff failed to report an incident of Abuse for two residents.	F 492		
F 497	NURSE AIDE PERFORM REVIEW-12 HR/YR	F 497		3/17/17

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F 497 SS=E	Continued From page 131 INSERVICE CFR(s): 483.35(d)(7) (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review the facility staff failed to ensure each nurse aide received no less than twelve hours of in-service education per year. The findings included: During the abbreviated survey deficient care practices were identified under Abuse Prohibition Policies and Procedures-Freedom from Abuse, Neglect and Exploitation, Immediate Jeopardy was called on 2/21/17 at 10:00 am The extended survey included the review of in-service education of nurse aides. The ADON (Assistant Director of Nursing)/SDC (Staff Development Coordinator) was asked to provide a list of all employed nurse aides annual 12 hours of in-service education to be calculated by employment date not calendar year. The list included 46 nurse aides. Six of those nurse aides did not meet the requirement of having received 12 hours of in-services education as follows: (1).Hire date 1/25/1990-5.45 hours	F 497	F-497 1. The six CNAs cited have obtained the hours needed to meet the 12 hour requirement annually on 2/23/17. 2. All residents are at risk for this issue. 3 A ADON will audit current CNAs for education hours to ensure that they have the required 12 hours by their anniversary date. 3 B CNAs identified as needing additional training hours prior to their anniversary will be scheduled for appropriate training. 3 C Each month the ADON or designee will audit training records of CNAs with approaching anniversary date. If additional training is required, it will be scheduled. 4. ADON will audit CNA training records quarterly to ensure they receive the required 12 hours of education annually. Audit results will be shared in the QAPI meetings. 5. 3/17/17	

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F 497	Continued From page 132 (2). Hire date 2/4/1998-8.45 hours (3). Hire date 1/16/2006-8 hours (4). Hire date 2/17/2009-3 hours (5). Hire date 1/3/12007-8 hours (6). Hire date 1/15/2013-0 due to Family Medical Leave, the Nursing Daily Sheets noted this CNA worked as recently as 2/2/17 and 2/5/17. On 2/23/17 at 1:05 pm, the ADON/SDC was asked for the facility policy for CNA in-service education. She stated, "We don't have a policy for CNA (Certified Nurse Aide) training...they need 12 hours a year". During the pre-exit meeting held on 2/23/17 the above findings was shared with the Administrator, the Director of Nursing, the Regional Vice President of Operations and the Compliance Nurse in attendance.	F 497		